

**LEGAL ASPECTS OF ACTIVE VOLUNTARY EUTHANASIA
IN AUSTRALIA**

by

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DECLARATION

This thesis contains no material which has been accepted for the award of any other higher degree or graduate diploma in any tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except when due reference is made in the text of the thesis.



Margaret Frances Anne Otlowski

ABSTRACT

This thesis examines the present criminal law position with respect to medically administered active voluntary euthanasia in Australia. Under existing criminal law principles, whilst there is some scope for passive euthanasia, active voluntary euthanasia is treated as murder and no account is taken of the special circumstances existing in such cases. Notwithstanding this prohibition, there is evidence that Australian doctors are involved in the practice of active voluntary euthanasia. However, police and prosecutors appear reluctant to intervene in this area of medical practice, and judging from the experience in other jurisdictions, there is every likelihood that if a doctor were prosecuted in Australia for having administered active voluntary euthanasia, the doctor would escape the full rigours of the criminal law. Against this background, this thesis seeks to highlight the problems which exist as a result of the marked discrepancies between law and practice in this area. Attention is also drawn to the law's differential treatment of active and passive euthanasia and the difficulties and anomalies which arise from the legal characterisation of a number of other medical practices which bear some similarity to active voluntary euthanasia such as the turning off of artificial life-support and the administration of pain-relieving drugs which are known to be likely to hasten the patient's death.

The thesis argues that active voluntary euthanasia should not be subject to a blanket criminal law prohibition. This argument is based on a number of factors including the principle of self-determination, current legal and medical practice, changing community attitudes, and jurisprudential arguments regarding the proper role of the criminal law. The conclusion of this thesis is that the law with regard to active voluntary euthanasia in Australia should be reformed by the introduction of legislation creating a very limited exception to the homicide laws that would confer on doctors an immunity from liability, provided active voluntary euthanasia is performed in accordance with strict criteria and safeguards. It is argued that the practice of active voluntary euthanasia by doctors in the Netherlands provides a useful guide to law reform in Australia.

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SELECT LIST OF ABBREVIATIONS

| | |
|----------------------|---|
| A.A.H.S. | Americans Against Human Suffering |
| A.H.E.C. | Australian Health Ethics Committee |
| A.M.A. | Australian Medical Association |
| B.M.A. | British Medical Association |
| C.H.A.B.I. | Ad Hoc Committee of Experts on Progress in Biomedical Science of the Council of Europe |
| C.M.A. | Canadian Medical Association |
| N.S.W. V.E.S. | New South Wales Voluntary Euthanasia Society |
| S.A.V.E.S. | South Australian Voluntary Euthanasia Society |
| V.E.S.Qld. | Voluntary Euthanasia Society of Queensland |
| V.E.S.Tas. | Voluntary Euthanasia Society of Tasmania |
| W.A.V.E.S. | Western Australian Voluntary Euthanasia Society |
| W.M.A. | World Medical Association |

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INTRODUCTION

While the problem of euthanasia is an ancient one,¹ it has, in recent years acquired a new relevance and urgency and is increasingly the subject of public debate. The current prominence of the issue can be attributed to a number of interrelated factors. One of the most significant has been the institutionalisation of the process of dying.² Developments in medical technology have significantly increased the capacity to sustain life beyond any possible hope of recovery. Patients who would in the past have died from natural causes can now be sustained almost indefinitely as a result of the intervention of artificial life-support equipment or other medical or surgical procedures. Whilst this has generally been a desirable development, it has created new legal and ethical problems in determining when to use medical interventions to attempt to save or prolong a patient's life and when a patient should be permitted to die. It has also posed new dilemmas as to when death has in fact occurred.³ One negative consequence of the tremendous advances in sustaining human life is that, in some instances, the dying process is unnecessarily prolonged. In fact, for many people, it is not death that they fear, but the possibility of dying in a painful and undignified manner.⁴ Thus, concern about the quality of life for the dying has prompted renewed interest in euthanasia.

Another factor which has contributed to the prominence of the euthanasia issue has been the growing proportion of elderly people in western society as a result of the general improvement in nutrition and health.⁵ Although the issue of euthanasia is not limited to the elderly, clearly those who are approaching the end of life are more likely to be concerned about the manner of their dying and to contemplate euthanasia. There has also been growing community awareness about patients' rights in the health care context, and voluntary euthanasia is regarded by many as providing the ultimate control over dying.

¹ According to a number of commentators, euthanasia was widely endorsed in the ancient world in cases of incurable disease by well-known figures such as Plato and the Stoic, Seneca. For an historical overview, see, for example, J. Wilson, *Death by Decision* (1975) 17-45; B. Fye, 'Active Euthanasia: An Historical Survey of its Conceptual Origins and Introduction into Medical Thought' (1978) 52 *Bull. of the History of Med.* 492; Gruman, G. 'An Historical Introduction to Ideas About Voluntary Euthanasia' (1973) 4 *Omega* 87; R. Russell, *Freedom to Die* (1977) 53-214; Steele, W. and B. Hill, 'A Plea for a Legal Right to Die' (1976) 29 *Okla.L.Rev.* 328, 330-332.

² President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 18; A. Capron, 'Legal and Ethical Problems in Decisions for Death' (1986) 14 *Law, Med. & Health Care* 141; C. Campbell, 'Aid-in-Dying and the Taking of Human Life' (1992) 18 *J.Med. Ethics* 128, 129.

³ Through legislative intervention, there is now fairly widespread acceptance of 'brain death' as death for the purposes of the law; see P. Bates and J. Dewdney, (eds.) *Australian Health and Medical Law Reporter* para. 19,200 for reference to relevant Australian legislation.

⁴ Russell, 35; Campbell, 129.

⁵ In 1986, 1.68 million people in Australia were aged 65 and over; 10.5% of the total population of 16 million. It is estimated that by the year 2005, 2.4 million people will be over 65; 11.9% of a total population of 20.2 million. By 2025 it is estimated that 3.8 million people will be over 65, 16.1% of a total population of 23.8 million; the *Bulletin* April, 1988.

The emergence of the AIDS epidemic has also played a role in drawing attention to the issue. With many of its victims being young and assertive, well informed of the unpleasant death they will face, the demand for control over the time and manner of one's dying has intensified.

Also of significance have been the gradually changing attitudes to death. For a long time, death has been regarded as a taboo subject, but there now appears to be greater appreciation of the issue and a growing demand for a 'good and dignified death'.⁶ The declining influence of religion has also contributed to the current prominence of the euthanasia issue. Whilst various religious denominations, most particularly the Catholic Church, have always been opposed to the concept of euthanasia, as a result of the increasing secularisation of society, there has been less opposition to the idea.

A further factor which has fuelled the current debate has been the influence of the media. In recent years there has been increased media coverage on euthanasia reflecting, to a large extent, the growing community interest in the subject. Through its extensive coverage, the media has also played a role in promoting debate and community awareness of the issue. Another consideration which has been at the background of the contemporary euthanasia debate is the availability of health care resources. As pressure mounts to contain expenditure and ensure the just allocation of finite health resources there has been growing recognition of the benefits of respecting individuals' choice not to be subject to prolonged and unwanted medical treatment and to have the option of electing an earlier death. As a result of these interrelated developments, the issue of euthanasia has come into prominence and the movement for the legalisation of active voluntary euthanasia has gained momentum.

The increasing prominence of the euthanasia issue has also revealed legal problems. Under existing criminal law principles, whilst there is some scope for passive euthanasia, active voluntary euthanasia is treated as murder and no account is taken of the special circumstances existing in such cases. There are, however, major discrepancies between law and practice in this area. There is evidence that active voluntary euthanasia occurs quite frequently (albeit largely as a hidden practice) yet doctors are virtually never prosecuted, or if prosecuted, have almost always escaped conviction. In addition to these discrepancies there are a number of inconsistencies and anomalies in the application of the law with regard to certain medical acts which may hasten death, in particular, switching off life-support and the administration of pain-relieving drugs.

The legal implications of doctors' participation in active voluntary euthanasia have been starkly brought into focus by the recent conviction of Dr Cox in the United Kingdom. In September 1992, Dr Cox, a consultant rheumatologist at a Winchester hospital, was convicted of the attempted murder of one of his patients and was given a 12 month suspended prison sentence.⁷ Dr Cox's crime had been to deliberately hasten the death of an elderly patient who was in excruciating and unrelievable

⁶ For a discussion of the changing attitudes to death, see P. Steinfels and R. Veatch, (eds.) *Death Inside Out* (1974).

⁷ This case is discussed in detail in chapter IV, 126-127. See also chapter VI, 279.

agony and who had begged him to relieve her of her suffering by administering a lethal dose of potassium chloride. What came as a surprise to many was not that this doctor had responded to a patient's request for active euthanasia: indeed, this is well-known to be a fairly common practice; but the fact that he was actually prosecuted and convicted of attempted murder. Prior to this case it has been widely assumed that a doctor, acting *bona fide* at the patient's request, would be immune from liability. The *Cox* case has dispelled any such belief and has highlighted the potential criminal liability of doctors who fulfil a patient's request for active euthanasia. Whilst many people have, in the past, been content to tolerate the inconsistencies which exist between medical practice and the strict letter of the law, the conviction of Dr Cox, a well respected and compassionate doctor, has forced a re-evaluation of the situation. The overwhelming reaction from the public has been one of sympathy and support for Dr Cox,⁸ and even the General Medical Council's professional conduct committee has effectively condoned his conduct by permitting him to continue working as a consultant and refraining from taking any serious disciplinary action against him.⁹ Not surprisingly, the case has been hailed as something of a watershed in the history of active voluntary euthanasia.¹⁰

The reality is that law does not presently distinguish between the *bona fide* act of a doctor hastening the death of a patient at the patient's request from an act of murder. The aim of this thesis is to examine the current legal prohibition of active voluntary euthanasia under Australian law and to consider whether there is a need for reform. Whilst consideration will principally be focused on the Australian position, where appropriate, attention will also be given to other common law jurisdictions, in particular, the United Kingdom and the United States. This work is primarily a legal analysis, but in view of the nature of the subject matter, the study necessarily involves consideration of wider issues, including social change, as reflected in opinion polls and community agitation for reform, the practice and attitudes of the medical profession, as well as consideration of religious, moral, and ethical arguments. In drawing attention to deficiencies in the present law with regard to active voluntary euthanasia, this work is intended to be of benefit to both doctors and patients; to protect doctors from the inappropriate imposition of criminal liability, and to protect the interests of patients and to promote their right of self-determination. This thesis also seeks to clarify the law and overcome much of the uncertainty which presently exists regarding the extent of a doctor's duty to a patient and the circumstances in which medical treatment can be withheld or withdrawn at the request of a patient who wants to die.

It is important from the outset to clarify the terminology which is used in this thesis, particularly in light of the variable meanings which are often attributed to the word 'euthanasia.' This lack of consensus in defining euthanasia is largely due to the emotive and controversial nature of the

⁸ In a telephone poll conducted by *News of the World* to gauge community reaction to the verdict, nearly 10,000 readers phoned in to register their response to the question: 'Should doctors be allowed to put patients out of their misery?' Of the respondents, 9,468, nearly 97%, called in to say yes. Only 326, just over 3%, voted no.

⁹ Dr Cox was admonished and given a reprimand by the General Medical Council, but was not struck off the medical register; the *Australian* 19 Nov. 1992.

¹⁰ See, for example, the *Independent* 21 Sept. 1992; R. Smith, 'Euthanasia: Time for a Royal Commission' 305 (1992) *B.M.J.* 728.

subject, and the fact that the definitions of euthanasia which are advanced, often reflect a particular moral viewpoint.¹¹ Etymologically, the word euthanasia means 'good death' from the Greek *eu* for good, and *thanatos* for death. In common usage, however, it is rarely used in this literal sense which emphasises the type of death experienced and is more usually employed to refer to the act of deliberately inducing the death of a patient who is in severe pain and distress as a result of a terminal or incurable illness. For example, euthanasia is defined in the Oxford dictionary as 'a gentle and easy death, the bringing about of this, especially in the case of incurable and painful disease.'¹² Although this definition makes no reference to the person who brings about this death, the contemporary understanding of euthanasia, upon which this thesis will focus, envisages a clinical situation where a doctor assists a terminal or incurable patient to die. This is to be distinguished from the more general concept of 'mercy killing', which can be defined as an intentional killing administered out of mercy or pity for the suffering person, often by a member of the family or a friend of the victim.¹³ In the interests of clarity, it is also desirable to dispense with the 'death with dignity' and the 'right to die' rhetoric. Whilst not wanting to detract from the importance of a dignified death, there is widespread agreement that these are ambiguous and meaningless phrases which do not assist in advancing reasoned analysis of the subject of euthanasia.¹⁴

In defining euthanasia, a distinction which in law is of utmost importance is the distinction between active and passive euthanasia. Although there is by no means universal agreement on the matter, the following definitions are proposed which are in accordance with the prevailing understanding of these terms. 'Active euthanasia' can be defined as a deliberate act to end the life of a terminal or incurable patient, which in fact results in the patient's death.¹⁵ An example of active euthanasia would be the deliberate administration of drugs with the object of causing the death of the patient and which does in fact result in the patient's death. 'Passive euthanasia'¹⁶ can be defined as the deliberate withholding or withdrawing of life-prolonging medical treatment in respect of a terminal or incurable patient, with the object of allowing the patient to die, and as a result of which the patient dies at an earlier time than he or she would have died had the treatment been carried out.¹⁷ An example of passive euthanasia would be the discontinuation of drugs, for instance, antibiotics in respect of a terminal or incurable patient who has an underlying infection.

¹¹ For a detailed analysis of the definition of euthanasia, see T. Beauchamp, and A. Davidson, 'The Definition of Euthanasia' (1979) 4 *J.Med. & Phil.* 294.

¹² *The Concise Oxford Dictionary of Current English* (7th ed. 1987) 332.

¹³ For a definition of 'mercy killing' see, for example, Law Reform Commissioner Victoria, Working Paper No. 8, *Murder: Mental Element and Punishment* (1984) 24; *The Concise Oxford Dictionary of Current English* (7th ed. 1987) 634.

¹⁴ See, for example, Parliament of Victoria Social Development Committee, Second and Final Report, *Inquiry into Options for Dying with Dignity* (1987) 139; President's Commission Report, *Deciding to Forgo Life-Sustaining Treatment* 24; G. Grisez and J.M. Boyle, *Life and Death with Liberty and Justice* (1979) 96-97.

¹⁵ See, for example, British Medical Association (B.M.A.) Working Party Report, *Euthanasia* (1988) 3 where 'active euthanasia' is described as 'an active intervention by a doctor to end life.'

¹⁶ Also sometimes referred to as 'antidysthanasia'; i.e. 'the failure to take positive action to prolong the life of an incurable patient'; see, for example, W. Cannon, 'The Right to Die' (1970) 7 *Hous.L.Rev.* 654, 657.

¹⁷ B.M.A. Working Party Report, *Euthanasia* 3; R. Kaplan, 'Euthanasia Legislation: A Survey and A Model Act' 2 (1976) *Am.J.L. & Med.* 41.

Although there is fairly wide acceptance of these terms, there has been considerable resistance to describing the practice of withholding or withdrawing life-prolonging medical treatment as a form of euthanasia. According to one view which has frequently arisen in medical circles, the discontinuation of medical treatment in appropriate circumstances is proper medical practice, and to describe it as 'passive euthanasia' is misleading and creates unnecessary confusion.¹⁸ Thus, it has been argued, there is a distinction between intentional killing on the one hand, and appropriate treatment for the dying or terminally ill on the other.¹⁹ Strong objections to the prevailing usage of 'passive' euthanasia have also come from various religious denominations, particularly the Catholic Church which has unequivocally condemned the practice of any form of euthanasia. According to traditional principles of Catholic teaching, there is a fundamental distinction between 'ordinary' and 'extraordinary' means of prolonging life.²⁰ This distinction has its origins in moral theology and is used to distinguish between forms of care which are obligatory (ordinary means) and non-obligatory care (extraordinary means). On the basis of this distinction, the Catholic view is that the term 'passive' euthanasia does not apply in respect of the withholding or withdrawing of 'extraordinary' treatment²¹ whereas the omission of an 'ordinary' means of prolonging life would be regarded as euthanasia.²² Apart from the Catholic Church, other religious denominations have also sanctioned non-intervention in appropriate circumstances claiming that this does not amount to euthanasia.²³ Apart from these sources of opposition, other commentators have argued that passive euthanasia is an inappropriate label for the withholding or withdrawing of treatment.²⁴ Despite this opposition, the term 'passive euthanasia' is now commonly used in this context,²⁵ and is an appropriate label in circumstances where the withholding or withdrawing was done with the object of hastening the death of the patient and did in fact bring about the patient's death.

Whilst acknowledging the limitations of this terminology, it is proposed, for the purposes of this thesis, to use the terms 'active' and 'passive' euthanasia. Apart from the fact that these terms have gained widespread usage and understanding, this approach can be justified on the basis that the distinction between 'active' and 'passive' euthanasia is closely paralleled by the acts/omissions

¹⁸ See, for example, B. Pollard, 'Killing the Dying - Not the Easy Way Out' (1988) 149 *M.J.A.* 312.

¹⁹ B. Reichenbach, 'Euthanasia and the Active Passive Distinction' 1 (1987) *Bioethics* 51, 72; R. Twycross, 'Debate: Euthanasia - A Physician's Viewpoint' (1982) 8 *J. Med. Ethics* 86, 87. The view has also been expressed that stopping treatment out of respect for a patient's wishes is not euthanasia at all; see S. Potts, 'Looking for the Exit Door: Killing and Caring in Modern Medicine' (1988) 25 *Hous.L.Rev.* 493, 500.

²⁰ For discussion of the historical background of this distinction, see the President's Commission Report, *Deciding to Forgo Life-Sustaining Treatment*, 82-83.

²¹ T. O'Donnell, 'Review of "The Physician's Responsibility Toward Hopelessly Ill Patients"' (1984) 51 *Linacre Q.* 351; D.W. Louisell, 'Euthanasia and Biathanasia: On Dying and Killing' 22 (1973) *Catholic U.L.Rev.* 723, 730.

²² W.B. Smith, 'Judeo-Christian Teaching on Euthanasia: Definitions, Distinctions and Decisions' 54 (1987) *Linacre Q.* 33.

²³ See, for example, K. Rayner, 'Euthanasia - A Church Perspective,' proceedings from the 5th Biennial National Aged Care Conference of the Uniting Church of Australia, Aug. (1986) 43.

²⁴ For example, R. Weir, *Abating Treatment with Critically Ill Patients* (1989) 302; E. Keyserlingk, *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law* (1979) 120-123. In fact, both these commentators argue that the distinction between active and passive euthanasia should be dispensed with altogether.

²⁵ For example, B.M.A. Working Party Report, *Euthanasia*, 3.

doctrine which underlies the criminal law and which is of central relevance in determining criminal liability. Thus, the position taken in this thesis is that whilst it may, in the future, be necessary to revise the nomenclature, it would not, for present purposes, advance the analysis of this subject if an attempt was made to depart from this terminology. Attention will, however, be drawn to some of the problems in the application of the acts/omissions distinction.

A critical feature of this work is its focus on *voluntary* euthanasia. Although the criminal law does not presently differentiate between euthanasia which is performed with or without the request of a patient, or indeed, against the patient's express wishes, the differences between voluntary euthanasia on the one hand, and involuntary and non-voluntary euthanasia on the other, are of paramount significance. It is therefore necessary to define these terms and to spell out the precise scope of this work. Euthanasia is involuntary where it is performed without the consent or against the will of a competent patient and this form of euthanasia should be condemned in the most emphatic terms. There are, however, those who advocate the acceptance of non-voluntary euthanasia in some circumstances, whereby euthanasia is performed on persons who are incompetent and therefore not capable of giving a consent.²⁶ The aim of this work is to deal solely with voluntary euthanasia; i.e. euthanasia which is performed at the request of the patient. This, in turn, involves an assumption about patient competence and decision-making capacity. Competence is not a legal status except when determined by a court of law,²⁷ and until such time as a formal judicial determination of incompetence is made, individuals are legally presumed competent to manage their own affairs.²⁸ In recent years, attention has moved away from the rather inflexible notion of competence to the concept of 'decision-making capacity'.²⁹ Decision-making capacity is now generally understood to refer to an individual's functional ability to make informed health care decisions in accordance with personal values.³⁰ However, the determination of patient capacity is extremely complex and there is, as yet, no consensus on the appropriate standard in determining capacity. As a minimum, it would require the ability to communicate and understand information relevant to the decision and the ability to reason and deliberate about the choices in accordance with personal values and goals.³¹ Capacity is not an all-or-nothing matter; there is a spectrum of abilities.³² The more serious the consequences of a particular decision, the higher the level of decision-making capacity required, and the greater need for certainty on the part of health care

²⁶ See, for example, M. Kohl, (ed.) *Beneficent Euthanasia* (1975); R. Young, 'Voluntary and Non-Voluntary Euthanasia' (1976) 59 *The Monist* 264; J. Rachels, *The End of Life* (1986); P. Singer, *Practical Ethics* (1979) 127-157.

²⁷ B. Dickens, 'Terminal Care, Incompetent Persons and Donation' (1986) 3 *Transplantation Today* 54.

²⁸ Hastings Center Report, *Guidelines on the Termination of Life-Sustaining Treatment and Care for the Dying* (1987) 131.

²⁹ See, for example, Hastings Center Report, *Guidelines on the Termination of Life-Sustaining Treatment and Care for the Dying*, 131-133; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions* (1982) 55-68.

³⁰ See, for example, Hastings Center Report, *Guidelines on the Termination of Life-Sustaining Treatment and Care for the Dying*, 132.

³¹ *Id.* 131; President's Commission Report, *Making Health Care Decisions*, 57.

³² Hastings Center Report, *Guidelines on the Termination of Life-Sustaining Treatment and Care for the Dying*, 133.

professionals in their assessment of that capacity.³³ Thus, the issue of active euthanasia would require a high degree of decision-making capacity in view of the significance of the decision and the finality of the outcome. In dealing with voluntary euthanasia, it is assumed, for the purposes of this thesis, that the patient is legally competent and has the requisite decision-making capacity to voluntarily elect an earlier death.

It is recognised that there are enormous ethical difficulties in making decisions concerning the care of incompetent patients since, unlike for competent patients, who can make decisions for their own health care, decisions must be made for another person, without guidance or knowledge of that person's wishes. However, because of the intrinsic differences between competent and incompetent patients, examination of this issue falls beyond the scope of this work.

At the heart of the euthanasia issue is the question whether individuals can rightly exercise control over the time and manner of their death. This raises the issue of an individual's right of autonomy and self-determination - the idea that competent individuals should be free to determine their own life choices. This principle underlies this thesis and it is proposed to explore its interrelationship with other important ethical principles and social values, prominent amongst which is the sanctity of life doctrine; the notion that human life has intrinsic value and is worthy of respect and protection. To the extent that the exercise of an individual's self-determination is in conflict with society's interest in the preservation of life, this thesis will also need to examine the relationship between private and public values and whether these interests can be reconciled.

It is important to acknowledge the close relationship between assisted suicide and active voluntary euthanasia. Because of the similarity of the issues involved, analysis of the issues with regard to active voluntary euthanasia has also necessarily entailed consideration of issues relevant to assisted suicide. Moreover, legalisation of active voluntary euthanasia would also require reconsideration of the terms of the current legal prohibition of assisting suicide. However, it must be recognised that notwithstanding the significant similarities, the issues are to some extent distinct.³⁴ The most obvious and important difference is that, unlike in the case of assisted suicide, where the death inducing agent is ultimately self-administered, active voluntary euthanasia requires the direct participation of another in bringing about the patient's death. The implications of this distinction are also examined in this thesis.

The thesis is divided into nine chapters. In the first two chapters, consideration is given to the legal status of medically administered euthanasia under the criminal law in Australia, focussing on the law's differential treatment of active and passive euthanasia. Chapter III contains an analysis of the law in relation to assisted suicide. Against this legal background, the position in practice with regard to active voluntary euthanasia is then explored in chapter IV. Evidence of doctors' involvement in the

³³ *Ibid.*; President's Commission Report, *Making Health Care Decisions*, 60.

³⁴ See R. Weir, 'The Morality of Physician-Assisted Suicide' (1992) 20 *Law, Med. & Health Care* 116, 117-118.

practice of active voluntary euthanasia and assisted suicide is analysed, and consideration is given to the treatment of such cases in the criminal justice system. Building on this analysis, attention is then drawn to the various problems which stem from the discrepancies which exist between law and practice in this area. In developing this argument, the discussion extends to a consideration of the legal characterisation of a number of other medical practices which bear some similarity to active voluntary euthanasia, yet which are typically characterised in such a way as to avoid the imposition of criminal liability.

Chapter V is devoted to an analysis of the euthanasia debate. This involves an examination of the arguments for and against the legalisation of active voluntary euthanasia as well as consideration of jurisprudential arguments regarding the role of the criminal law. In chapter VI, changes in society are discussed which have contributed to a more receptive climate for reform. Particular attention is given to the evidence of growing support for the legalisation of active voluntary euthanasia amongst the medical profession and in the community generally. Consideration is then given in chapter VII to the reform developments which have occurred in Australia and other common law jurisdictions, including law reform commission and parliamentary inquiries dealing with the subject and efforts to secure legislative reform. In chapter VIII attention is turned to the Netherlands where, although not actually legalised, active voluntary euthanasia has for some years been openly practiced by the medical profession with very few legal repercussions. Since the Netherlands has come to be widely regarded as a possible reform model, an attempt is made to carefully evaluate the situation and to ascertain whether it is in fact a suitable model for other jurisdictions to adopt.

The final chapter deals with options for reform. The suitability of a legislative response is examined and criteria are considered for the legalisation of active voluntary euthanasia. The conclusion of this thesis is that, notwithstanding the limitations of legislation, on balance, legislative reform is both necessary and appropriate. A recommendation is accordingly made for the introduction of a very limited exception to the homicide laws that would confer on doctors an immunity from liability, provided active voluntary euthanasia is performed in accordance with strict criteria and safeguards.

There could be little dispute that the question whether active voluntary euthanasia should be permitted by law raises problems of fundamental importance and considerable difficulty. It is hoped that this thesis will assist in clarifying the issues and advancing the debate so as to pave the way for reform.

CHAPTER I

EUTHANASIA UNDER AUSTRALIAN CRIMINAL LAW

Introduction

The object of this chapter is to examine the present state of the criminal law regarding the practice of active and passive euthanasia in Australia with the aim of ascertaining the potential liability of doctors for participation in these practices. As was observed in the Introduction to this thesis, some aspects of the present law are shrouded in uncertainty. This is particularly the case in relation to liability for the withholding or withdrawing of medical treatment which results in the death of the patient. As a result of this uncertainty, many health care professionals are unsure of their precise legal rights and obligations.¹ This tends to encourage doctors to practice 'defensive medicine' which may be contrary to the patient's interests. The examination in this and the following chapter, dealing with the patient's right to refuse treatment, seeks to clarify some of the prevailing uncertainties in respect of the rights of patients regarding their medical treatment and the legal position of doctors acting on the instructions of their patients. In the course of this analysis, attention will also be focussed on the differential treatment of the law in respect of active and passive euthanasia. Notwithstanding the similarities between active and passive euthanasia in terms of intention and outcome, there are significant legal differences between the two, which give rise to questionable distinctions.

The distinction between active and passive euthanasia essentially rests upon the more general distinction between acts and omissions; active interventions as distinct from non-action or refraining from acting. The criminal law maintains a fairly rigid distinction between liability for acts which cause death on the one hand, and liability for omissions which cause death on the other. This has significant implications for the law regarding active and passive euthanasia. In analysing the criminal law in relation to euthanasia, it will therefore be necessary to examine criminal liability for both acts and omissions which cause death. This will be dealt with in parts I and II of this chapter respectively.

It should, however, be noted from the outset that the distinction between active and passive euthanasia and the underlying acts/omissions doctrine is most problematic and unsatisfactory. In the chapters which follow, it will be argued that this distinction is of questionable moral and philosophical significance. Further, it will be shown that this distinction is often difficult to maintain in practice. The practical difficulties in drawing the distinction in particular cases has been compounded by the

¹ See, for example, the findings of the Parliament of Victoria Social Development Committee, Second and Final Report *Inquiry into Options for Dying with Dignity* (1987) 43-48 (hereafter referred to as the Victorian Social Development Committee Report).

widespread reluctance to characterise as criminal certain conduct regularly performed in medical practice. Two aspects of medical practice which are highlighted in this thesis are the switching off of artificial life-support and the administration of pain-relieving drugs which are known to be likely to hasten death. It will be demonstrated in a later chapter that this tendency to avoid labelling medical conduct as criminal, whilst readily understandable, has resulted in serious distortions in the interpretation and application of the law.² However, notwithstanding the difficulties with the acts/omissions distinction, for the purposes of the present discussion regarding the criminal law it is nevertheless necessary to adhere to this distinction as it continues to have overriding legal significance.

Although there are some significant variations in the criminal law as between the various jurisdictions,³ the law applicable to euthanasia performed by a doctor at the request of a patient is fairly uniform throughout Australia. In all Australian jurisdictions, the criminal law does not recognise euthanasia as a special category of homicide. Liability in respect of such conduct is determined on the basis of the ordinary criminal law principles. As outlined in the Introduction to this thesis, euthanasia, as defined for the purposes of this study, involves the deliberate and intentional causing of death either by active or passive means. We are therefore dealing with *intentional* killing as distinct from death caused as a result of *negligent* acts and omissions. Accordingly, the relevant law is that pertaining to murder.⁴

In order to establish liability for murder, both the *actus reus* and the *mens rea* for the crime of murder must be made out. The necessary *mens rea* or mental element for the crime of murder includes an intention to kill. The *actus reus* of a crime has been described as the external ingredients of the crime⁵ or alternatively, as all the elements in the definition of the crime, except the defendant's mental element.⁶ The *actus reus* for the crime of murder requires proof of particular conduct and, that as a matter of causation, the defendant's conduct *caused* the death in question. The requisite conduct of the defendant can be either an act, in the sense of a willed bodily movement, or an omission; i.e. non-action or failure to act. Omissions have a different status under the criminal law than do acts. Whilst the duty not to actively cause harm is virtually absolute, there is no general principle of liability for failure to act and prevent the occurrence of harm. An omission to act which causes death will only give rise to criminal liability in circumstances where the criminal law imposes a *legal duty* to act.

² See chapter IV, 150-175.

³ There are a number of distinct sources of homicide law in Australia; the common law which applies with little legislative interference in Victoria and South Australia; the Criminal Codes of the Northern Territory, Queensland, Tasmania and Western Australia (N.T. *Criminal Code* 1983; Qld. *Criminal Code* 1899; Tas. *Criminal Code* 1924; W.A. *Criminal Code* 1913); and the *Crimes Act* 1900 (N.S.W.) which applies in New South Wales. The *Crimes Act* 1900 (N.S.W.) was made applicable to the Australian Capital Territory (s. 6(1) of the Seat of Government Acceptance Act 1909) subject to amendment by Australian Capital Territory Ordinances; see, for example, *Crimes (Amendment) Ordinance (No. 2)* 1990 (A.C.T.). It should be noted that at the time of writing, a review is being undertaken of the Queensland *Criminal Code*; see the *First Interim Report of the Criminal Code Review Committee to the Attorney-General* (1991).

⁴ The law relating to manslaughter will therefore not be directly considered.

⁵ G. Williams, *Textbook of Criminal Law* (2nd ed., 1983) 146.

⁶ J.C. Smith and B. Hogan, *Criminal Law* (5th ed., 1983) 31.

The common law has traditionally been very circumspect in imposing a legal duty to prevent harm. Under the criminal law in all Australian jurisdictions, a duty to act only arises in certain specified circumstances. One of the special relationships which gives rise to a legally recognised duty to act is the relationship of doctor and patient, although the extent of this duty will depend on the circumstances of the case.⁷ The omission by a doctor of his or her legal duty towards a patient may give rise to criminal liability for murder, provided that it can be established, as a matter of causation, that the relevant omission was the cause of death and that the doctor intended to bring about the death of the patient.⁸

These key elements of Australian law with regard to euthanasia are paralleled by the criminal law in comparable overseas jurisdictions, including the United Kingdom, upon which the Australian law is largely based, and the law in the United States, Canada and New Zealand.⁹

PART I

Doctors' Criminal Liability for Acts Which Cause Death

Introduction

In this part of the analysis, it is proposed to examine the criminal liability of a doctor in respect of a deliberate act of euthanasia performed at the request of the patient which results in the patient's death. This area of the law, involving euthanasia by affirmative conduct performed at the patient's request, can be stated with some certainty. In order to establish criminal liability it must be shown that there was some act committed by the doctor which was intended to cause death and which did in fact cause the patient to die at that time and in that manner. The fact that the doctor committed the acts which caused death at the patient's request does not exculpate a doctor from criminal liability since a person cannot validly consent to his or her own death. Furthermore, for the purposes of establishing criminal liability for murder, the law takes no account of the motive of the doctor or the fact that the death may in any event have been imminent by virtue of the patient's terminal condition. There are no special defences which would apply to protect doctors from incurring criminal liability in these circumstances.

⁷ The extent of the doctor's duty and in particular, the legal effect of a patient's right to refuse treatment on a doctor's duty to treat is dealt with in the following chapter.

⁸ In some circumstances, *mens rea* short of intention will suffice to establish liability for murder. See below, 28-29.

⁹ In the United States, criminal law comes within the jurisdiction of the States, some of which rely predominantly on common law, whilst others have codified their criminal law. Canada has a federal Code; *Criminal Code* R.S.C. 1985, c. C-46. In New Zealand, the relevant legislation is the *Crimes Act* 1961. (Reform of this legislation has for some time now been on the agenda; see the *Crimes Bill* 1989 which at the time of writing was still before the Justices Law Reform Select Committee. The New Zealand Government has, however, decided not to proceed with this Bill (prepared by the previous government) and intends to introduce its own Bill. (Verbal communication with an official from the New Zealand Justice Department, March 1992.)

The Acts

Although the distinction between acts and omissions is fundamental in the law of homicide, there are no universally accepted criteria for distinguishing between them.¹⁰ Indeed, there is considerable confusion and uncertainty even in defining what is meant by 'an act'.¹¹ Professor Glanville Williams is of the view that the most acceptable language is to describe an act as a 'willed bodily movement'.¹² This description is in accordance with Justice Holmes' classic definition of an act as a 'voluntary muscular contraction'.¹³ If one proceeds on the basis that an act involves some willed bodily or muscular movement,¹⁴ it is possible to identify certain conduct as clearly coming within this definition. In the context of medically administered active euthanasia the most obvious example of an act causing death is for the doctor to administer to the patient a lethal injection.

The Intention Requirement

In order to establish liability for the crime of murder, the relevant *actus reus*, (here the act causing death), must be accompanied by the necessary *mens rea*. The mental element for murder at common law is traditionally referred to as 'malice aforethought'.¹⁵ This term has acquired a highly technical meaning quite different from the ordinary popular usage of the words themselves.¹⁶ The reference to 'malice' is particularly misleading when considered in the context of active voluntary euthanasia where the relevant conduct causing death is performed out of compassionate and benevolent motives. The term 'malice aforethought' simply describes a number of different states of mind which will satisfy the *mens rea* requirement for the crime of murder.¹⁷ Neither malice (in the sense of ill will) or premeditation need in fact be established. Malice aforethought at common law clearly encompasses an *intention to kill* any person. It also includes an intention to inflict grievous bodily harm.

¹⁰ P. Skegg, 'The Termination of Life-Support Measures and the Law of Murder' (1978) 41 *Mod.L.Rev.* 423, 427.

¹¹ See G. Hughes, 'Criminal Omissions' (1957-8) 67 *Yale L.J.* 590, 597 where he notes that no agreed juristic concept of an act exists and then goes on to discuss some of the suggested definitions.

¹² Williams, *Textbook of Criminal Law*, 147-148.

¹³ O.W. Holmes, *The Common Law* (1881) 91. This description has, however, been subject to criticism; see Hughes, 597 where he argues that this definition is not very helpful for the purposes of the criminal law since the criminal law has never prohibited mere muscular contractions; what is needed is reference to muscular contractions, in certain circumstances, and with certain consequences. Note also the concept of 'act' in the Austinian sense, of a movement of the body consequent upon the exercise of the will; J. Austin, *Lectures on Jurisprudence or the Philosophy of Positive Law* (1920) 174.

¹⁴ Note, however, the view of some commentators, for example, G. Fletcher, 'Prolonging Life' (1967) 42 *Wash.L.Rev.* 999 that certain conduct should be classified as an omission, notwithstanding that it involves bodily movement. For further discussion, see chapter IV, 152-155.

¹⁵ See the definition of murder at common law by Sir Edward Coke, *Institutes of the Laws of England* 47.

¹⁶ Smith and Hogan, 291.

¹⁷ L. Waller and C.R. Williams, *Brett, Waller and Williams Criminal Law* (6th ed., 1989) 143-144.

Similarly, under the statutory definition of murder in s. 18 of the *Crimes Act* 1900 (N.S.W.)¹⁸ and the various Criminal Codes in Australia, the *mens rea* for murder includes an intention to cause death or grievous bodily harm.¹⁹

Thus, in circumstances where a doctor deliberately responds to a request from a patient that he or she take active steps to bring about the patient's death, the necessary intention requirement for the crime of murder in all Australian jurisdictions will be established, since the doctor clearly intends to bring about the death of the patient.

The Causation Requirement

A fundamental component of the *actus reus* for the crime of murder is that the conduct of the defendant *caused* the death of the deceased. There are two distinct aspects to the legal principle of causation at common law; the *sine qua non* test and the issue of imputability.²⁰

First of all, it is necessary to establish that the defendant's conduct (whether an act or an omission) is a *sine qua non* of the event; that is, one must be able to say that 'but for' the occurrence of the antecedent factor the event would not have happened.²¹ This will be a question of fact in each case, and must be established by the prosecution beyond reasonable doubt. In addition to this 'but for' requirement, it will also be necessary to show that the defendant's conduct is an imputable or legal cause of the consequence; in other words, that the defendant's conduct is sufficiently connected with the consequences so as to attribute to him or her legal responsibility for those consequences.²² This aspect of the causation test has been variously described as the direct, proximate, substantial or effective cause. According to Williams, these terms can be misleading and the real question is essentially a value judgment, whether the result can fairly be said to be imputable to the defendant.²³ Whether there is sufficient evidence to support a finding of imputable cause is a question of law for the determination of the court. If the court is of the opinion that there is sufficient evidence to support such a finding, the question of the defendant's guilt or innocence will be left to the jury.²⁴ However, there are, as yet, no clear principles regarding the appropriate direction to the jury on this aspect of causation.²⁵ Various formulations have been used, including that the defendant's act or omission

¹⁸ But note s. 12(1) *Crimes (Amendment) Ordinance (No. 2)* 1990 (A.C.T.) which has, for the purposes of the law in the Australian Capital Territory, modified the operation of the *Crimes Act* 1900 (N.S.W.).

¹⁹ N.T. s. 162 (refers to 'grievous harm' rather than 'grievous bodily harm'); Qld. s. 302; W.A. ss. 278 and 279. It should be noted that in Western Australia, the intentional causing of death is defined as 'wilful murder' (s. 278) and all other forms of murder are defined as 'murder'. Under the Tasmanian *Criminal Code* 1924 an intention to cause grievous bodily harm will only be sufficient to establish the *mens rea* for murder if it was done for the purpose of facilitating the commission of a specific crime; see s. 157(1)(d).

²⁰ Williams, *Textbook of Criminal Law*, 379-384.

²¹ *Id.* 379.

²² *Id.* 381.

²³ *Ibid.*

²⁴ *Howard's Criminal Law* (5th ed., 1990 by B. Fisse) 33.

²⁵ Williams, *Textbook of Criminal Law*, 382; Fisse, 34-35.

must have 'contributed significantly to the death',²⁶ or alternatively, that it must have been a 'substantial cause of the death.'²⁷ Whatever the formulation used, it is at least clear that the conduct of the defendant must not be so minute or trivial that it will be ignored under the *de minimis* principle.²⁸

The common law principles in respect of causation have been incorporated into the Australian Criminal Codes.²⁹ For example, s. 153(1) of the Tasmanian *Criminal Code* 1924 provides:

Killing is causing the death of a person by an act or an omission but for which he would not have died when he did, and which is directly and immediately connected with his death.

This section clearly incorporates both the common law requirements of *sine qua non* and imputability.³⁰

On the basis of the foregoing principles, in circumstances where a doctor performs certain acts which are intended to bring about the patient's death, and the patient's death ensues some short time thereafter as a direct result of those acts, the legal requirements of causation are clearly made out. The doctor's conduct is a *sine qua non* of the patient's death in that 'but for' the occurrence of the act the patient would not have died. The doctor's conduct would also appear to be an imputable or legal cause of the patient's death since it is sufficiently connected with the death so as to attribute to him or her legal responsibility for that consequence.

It is clear that the act of the doctor need not be the *sole* or indeed the *main* cause of death of the patient.³¹ It is enough if, as a matter of law, it is a cause which has the effect of accelerating the moment of the patient's death.³² Circumstances may arise where the acts committed by the doctor which caused the death of the patient would not have resulted in the death of a healthy person. For example, the administration of certain drugs may have greater effect upon a sick person in a debilitated state than they would upon an ordinary person. A doctor committing such acts would nevertheless be liable (provided the necessary *mens rea* is also established) since the doctor's conduct was sufficiently connected with the patient's death so as to hold the doctor legally responsible for that consequence.³³

²⁶ *Smithers v R* (1977) 34 C.C.C. (2d) 427.

²⁷ *R v Evans and Gardiner* (No. 2) [1976] V.R. 523; *Hallet v R* [1969] S.A.S.R. 141, 150; *R v Singapore* (1975) 11 S.A.S.R. 469, 480.

²⁸ See Smith and Hogan, 279, referring to the case of *R v Cato* [1976] 1 All E.R. 260, 265. For a discussion of the defence of minimal causation, see Williams, *Textbook of Criminal Law*, 385.

²⁹ N.T. s. 157; Qld. s. 293; Tas. s. 153(1); W.A. s. 270. Note also s. 222 of the Canadian *Criminal Code* 1985; s. 158 of the New Zealand *Crimes Act* 1961.

³⁰ See also the reference to the requirement of causation in s. 18 *Crimes Act* 1900 (N.S.W.) which can be taken to include both the *sine qua non* and imputability test.

³¹ Smith and Hogan, 278.

³² *R v Cato* [1976] 1 All E.R. 260, 265.

³³ The separate question of the administration of pain-relieving drugs which may hasten death is dealt with in chapter IV, 163-175.

However, the doctor's contribution to the death of the patient must not be so insignificant that it would be ignored under the *de minimis* principle.³⁴

Irrelevance of Patient's Terminal Condition

It may be that active euthanasia is performed in respect of a terminal patient, whose death is imminent from natural causes. It is, however, no defence to a charge of murder that the death was in any event imminent by virtue of the patient's terminal condition. This is the position both at common law and under the Australian Criminal Codes.

Position at Common Law

As Devlin stated in his work *Samples of Lawmaking*:³⁵

The deliberate acceleration of death must *prima facie* be murder and I do not see how under any system of law it can logically be otherwise. The certainty of death in the immediate future cannot of itself be a defence any more than the certainty in the remote future.

Indeed, since death is, sooner or later, inevitable for all of mankind, *every* killing can be regarded as being simply an acceleration of an inevitable death. Consequently it will make no difference to the liability of the defendant that the victim was suffering from a terminal condition. Accordingly, in *R v Dyson*,³⁶ the defendant was indicted for the manslaughter of a young boy who had died from injuries the defendant had inflicted, notwithstanding the fact that the child was at the time suffering from meningitis from which he would have died in any event. Lord Alverston C.J. stated that:

The proper question to have been submitted to the jury was whether the prisoner accelerated the child's death by the injuries which he inflicted. For if he did the fact that the child was already suffering from meningitis from which it would in any event have died before long, would afford no answer to the charge of causing its death.³⁷

The same principle has been formulated by courts in the United States in the following terms:

That if any life at all is left in a human body, even the least spark, the extinguishment of it is as much homicide as the killing of the most vital being.³⁸

The strictness of the criminal law with respect to active euthanasia is only explicable in the context of the common law philosophy regarding the value of human life. Strongly influenced by ecclesiastical teaching, the attitude of the common law has been to uphold life as sacred and

³⁴ Smith and Hogan, 279-280.

³⁵ (1962) 94-95.

³⁶ [1908] 2 K.B. 454.

³⁷ *Id.* 457. See also *R v Pankotai* [1961] Crim.L.R. 546; *R v Morby* (1882) 8 Q.B.D. 571, 575.

³⁸ *State v Francis* 152 S.C. 17 (1929).

inalienable.³⁹ The strength of the common law belief in the sacredness of life is demonstrated by the fact that protection of the criminal law extends to all persons, even those who are already dying. Thus, the fact that an act of euthanasia was performed in respect of a terminally ill patient, whose death was in any event imminent, does not prevent liability from arising. All that needs to be shown is that as a result of the doctor's act, death occurred at the time and in the manner in which it did.⁴⁰ It should be noted, however, that the condition of the patient may still be relevant, in so far that it must be established that the alleged criminal act and not the terminal illness from which the patient was suffering was, as a matter of causation, the proximate or substantial cause of death.⁴¹ Whilst the mere acceleration of death will suffice to establish criminal liability, it must not be so minimal or trivial that it will be disregarded under the *de minimis* principle.⁴²

Position Under the Codes

The position under the Criminal Codes in Australia regarding the condition of the patient, and the acceleration of an imminent death is the same as at common law. Under s. 154(d) of the Tasmanian *Criminal Code*, a person is deemed to have killed another where, by an act or omission, he or she hastens the death of another who is suffering under any disease or injury which would itself have caused death, even though his or her act or omission is not the immediate or the sole cause of death. Similar provisions are contained in the Codes of Queensland and Western Australia.⁴³ The effect of these provisions is to restate the common law rule that the causing of death of a person will constitute murder regardless of that person's condition and the fact that death may in any event have been imminent. Although these various provisions were not drafted specifically with active euthanasia in mind,⁴⁴ they clearly cover cases where the death of a person has been accelerated as a result of an act of euthanasia. Thus, a doctor who commits such an act is, by virtue of these provisions, deemed to have killed the patient for the purposes of the law of murder.

Irrelevance of Patient's Consent

Generally speaking, the consent of the victim is not a defence for the purposes of the criminal law.⁴⁵ In *R v Donovan*⁴⁶ it was held that:

³⁹ *State v Moore* 25 Iowa 128, 135-136 (1868).

⁴⁰ Fisse, 33.

⁴¹ P. MacKinnon, 'Euthanasia and Homicide' (1983-4) 26 *Crim.L.Q.* 483, 493.

⁴² Smith and Hogan, 280.

⁴³ Sections 296 and 273 respectively. Note also s. 226 of the Canadian *Criminal Code* 1985; s. 164 New Zealand *Crimes Act* 1961.

⁴⁴ I. Temby, 'Euthanasia - Is It Murder?' (1988) 21 *A.J.F.S.* 2, 5.

⁴⁵ D. O'Connor and P.A. Fairall, *Criminal Defences* (1988) 92. The common law position, as outlined above, also applies in the A.C.T. and N.S.W. since the *Crimes Act* 1900 (N.S.W.) is silent on this matter.

⁴⁶ [1934] 2 K.B. 498.

If an act is unlawful in the sense of being in itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it. No person can licence another to commit a crime.⁴⁷

Thus, the common law position regarding the effect of consent upon the question of criminal liability for murder is abundantly clear; a person cannot lawfully consent to his or her own death.⁴⁸ As was stated in the Scottish case of *H.M. Advocate v Rutherford*⁴⁹ by the High Court of Justiciary in Scotland:

If life is taken under circumstances which would otherwise infer guilt of murder, the crime does not cease to be murder merely because the victim consented to be murdered, or even urged the assailant to strike the fatal blow.⁵⁰

It is clear from this passage that it makes no difference if the consent of the victim is mere consent, in the sense of acquiescence in what another proposes, or, at the other extreme, a positive direction or request from a person that he or she be assisted to die.⁵¹

Similarly, under the Criminal Codes in Australia, it is irrelevant for the purposes of determining criminal responsibility, that the person killed requested or consented to his or her own death. Section 53(a) of the Tasmanian *Criminal Code* 1924 provides that:

No person has a right to consent to the infliction of death upon himself and any consent given in contravention hereof shall have no effect as regards criminal responsibility.

Equivalent provisions exist in the Codes of the other Code jurisdictions.⁵²

Rationale Behind the Criminal Law Prohibition on Consent to Death

In order to evaluate the status of this criminal law principle it is important to understand the rationale which underlies it. The authoritarian stance of the criminal law regarding consent to death is based

⁴⁷ *Id.* 507. See also *R v McLeod* (1915) 34 N.Z.L.R. 430, 433-434.

⁴⁸ *R v Cato* [1976] 1 All E.R. 260. The common law prohibition on consent applies not only to death, but also to the infliction of bodily harm; see *R v Donovan* [1934] 2 K.B. 498; *Attorney-General's Reference (No. 6 of 1980)* [1981] 1 Q.B. 715. The law in relation to suicide (as distinct from assisted suicide) is an obvious exception to the principle that one cannot consent to one's own death. See chapter III, 83.

It should be noted that in some civil law jurisdictions including Germany, Norway and Switzerland, homicide performed at the request of the victim is treated as a lesser offence. See chapter IX, 404.

⁴⁹ [1947] J.C. 1.

⁵⁰ *Ibid.* Note also the American case of *Turner v State* 119 Tenn. 663, 671 (1908) in which it was stated that 'murder is no less murder because the homicide is committed at the desire of the victim. He who kills another upon his desire or command is, in the judgment of the law, as much a murderer as if he had done it merely of his own head'.

⁵¹ For a discussion of the definitions and meaning of consent see J.G. Castel, 'Nature and Effects of Consent With Respect to the Right to Life and the Right to Physical and Mental Integrity in the Medical Field: Criminal and Private Law Aspects' (1978) 16 *Alta.L.Rev.* 293, 294.

⁵² N.T. s. 26(3); Qld. s. 284; W.A. s. 261. Note also s. 14 of the Canadian *Criminal Code* 1985; s. 63 of the New Zealand *Crimes Act* 1961.

upon the belief that the taking of life is a wrong, not only to the person killed, but also to the entire society.⁵³ In the words of Devlin:

The reason why a man may not consent to the commission of an offence against himself beforehand or forgive it afterwards is because it is an offence against society.⁵⁴

The common law tradition has always been to uphold human life as sacred and inalienable, thereby securing the general protection of human life, as well as maintaining social order and promoting the wider interests of society as a whole. Thus, the preservation of life has been accorded priority over the autonomy of the individual and consequently, as a matter of public policy, the consent of the victim has never been recognised as a defence to a criminal homicide.⁵⁵

Thus, the fact that the patient consented to his or her own death or even instigated the request does not exculpate the doctor from criminal liability. Although under common law principles, a patient has the right to accept or reject medical treatment,⁵⁶ a patient cannot validly consent to or authorise a doctor to perform an act which brings about that patient's death. The special nature of the doctor/patient relationship does not affect the general principles regarding the irrelevance of the victim's consent.

Irrelevance of Motive

A doctor who responds to a patient's request that he or she take active steps to bring about the patient's death would almost invariably be acting out of humanitarian motives. Indeed, the motivation of the doctor is one of the distinguishing features of active voluntary euthanasia which, in the popular mind, clearly sets it apart from more reprehensible forms of killing.⁵⁷ Notwithstanding this seemingly obvious difference between active voluntary euthanasia and other forms of killing, the compassionate motive of a doctor does not protect him or her from criminal liability for murder. Furthermore, irrespective of the special nature of the doctor/patient relationship, it would be irrelevant that the acts causing death were deliberately performed by a doctor in the course of medical practice.⁵⁸

⁵³ See the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 33. (Cited hereafter as the President's Commission Report.) See also McInerney J. in *Pallante v Stadiums Pty Ltd* [1976] 1 V.R. 331, 340 where, after noting the case of *R v Donovan* [1934] K.B. 498 (involving charges of common and indecent assault arising from the accused having beaten a girl for his sexual pleasure), his Honour commented on the philosophy underlying the common law; 'It injures society if a person is allowed to consent to the infliction on himself of such a degree of serious physical harm.' See generally Castel.

⁵⁴ P. Devlin, *The Enforcement of Morals* (1965) 6.

⁵⁵ Williams, *Textbook of Criminal Law*, 576-577.

⁵⁶ In Victoria, South Australia and the Northern Territory, and in many of the United States jurisdictions, patients also have a statutory right to refuse treatment in some circumstances. For discussion, see chapter VII, 294-311, 326-337.

⁵⁷ W. Baugham, J. Bruha and F. Gould, 'Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations' (1973) 48 *Notre Dame Law*. 1202, 1205.

⁵⁸ P. Skegg, *Law Ethics and Medicine* (1984) 130 where he refers to the judgments of Devlin J. in *R v Adams* (unreported) (1957). See H. Palmer, 'Dr Adams' Trial for Murder' (1957) *Crim.L.Rev.* 365; Farquharson J. in *R v Arthur* (unreported) *The Times*, 6 Nov. 1981.

Under general criminal law principles, a sharp distinction is made between motive and intention. Whilst the issue of intention is clearly central to the requirement of *mens rea*, both at common law⁵⁹ and under the Codes,⁶⁰ motive is quite irrelevant for the purposes of establishing criminal liability.⁶¹ It should, however, be noted that although motive is irrelevant to the question of criminal liability, it may be relevant with respect to sentencing once liability is found to be established.⁶²

PART II

Doctors' Criminal Liability for Omissions Which Cause Death

Introduction

It is widely believed that there is an important moral and practical difference between active and passive euthanasia; between 'killing' and 'letting die',⁶³ and it is often assumed that this distinction has legal significance as well. The word 'killing' clearly implies some active involvement with the death of the patient, whilst 'letting die' is regarded as simply letting nature take its course without any involvement of the medical profession in the death of the patient. Although this distinction between killing and letting die has gained widespread usage and appears to have had a significant influence on medical practice, it is not necessarily a valid distinction for legal purposes. The reality of the matter is that cases of 'letting die' by withholding or withdrawing treatment may well give rise to criminal liability. However, in contrast to the area of euthanasia by affirmative acts (active euthanasia), the law regarding euthanasia by omission (passive euthanasia) is shrouded in unnecessary confusion and uncertainty.

In this part of the analysis, it is proposed to examine the criminal law principles with respect to murder as they apply to the deliberate omission of medical treatment by a doctor which results in the death of a patient. The object of this exercise is to demonstrate that most of the ingredients for criminal liability for murder can be made out in circumstances where a doctor performs passive

⁵⁹ See Lord Hailsham in *Hyam v Director of Public Prosecutions* [1975] A.C. 55, 73 for a discussion of the distinction between intention and motive. The common law position, as outlined above, also applies in the A.C.T. and N.S.W. since the *Crimes Act* 1900 (N.S.W.) is silent on this matter. Compare the common law position with that of some European criminal law systems, for example Germany and Switzerland, where motive is a crucial factor in determining the culpability of an accused. See chapter IX, 404.

⁶⁰ Qld. s 23; Tas. s. 13(4); W.A. 23.

⁶¹ Note, however, the position in some civil law jurisdictions where the motive of the accused is taken into account in determining criminal liability. See H. Silving, 'Euthanasia: A Study in Comparative Criminal Law' (1954) 103 *U.Pa.L.Rev.* 350.

⁶² This, in turn, depends on whether any sentencing discretion is vested in the courts. Whilst in most Australian jurisdictions, life imprisonment is mandatory for murder, in New South Wales, Victoria and the Australian Capital Territory, the sentence is discretionary; s. 19 *Crimes Act* 1900 (N.S.W.) (as amended in 1982); s. 3 *Crimes Act* 1958 (Vic.) (as amended in 1986). In the Australian Capital Territory, the position is governed by s.442(1) of the *Crimes Act* 1900 (N.S.W.) as amended by s. 23 of Ordinance No. 11 of 1963. For an interpretation of this provision see *R v Wheeldon* [No.1] 1978 33 F.L.R. 402.

⁶³ For consideration of the contrary view, see chapter V, 181-183.

euthanasia; i.e. if a doctor deliberately omits life-sustaining treatment which he or she is under a legal duty to provide, with the object of facilitating the death of the patient, and the patient dies as a result. In turn, the fact that the conduct of doctors in withholding or withdrawing treatment could, potentially at least, be subject to criminal liability for murder highlights the necessity of closely examining the precise *scope* of the doctors duty towards his or her patient and the legal effect of a patient's right to refuse treatment on the doctor's duty to treat. This will be the subject of separate consideration in the chapter which follows.

The Omission

As noted earlier, the *actus reus* for the crime of murder can be either an act or an omission. As generally understood, an 'omission' involves non-performance or inaction in circumstances in which a person knows he or she has the ability and opportunity to act so as to prevent a particular result, but refrains from doing so.⁶⁴ In the medical context, this would involve the deliberate omission of medically indicated treatment which is reasonably available,⁶⁵ and the administration of which would have prevented the patient from dying at that time and in that manner.⁶⁶

Attitude of the Law to Omissions and the Duty Requirement

Under criminal law principles, a fairly strict distinction has been drawn between liability for *acts* which cause death, and liability for *omissions* which cause death. Acts which cause death are almost always wrongful, and will attract criminal liability for murder if they are accompanied by the necessary *mens rea* for the crime of murder. However, liability for omissions is exceptional. An omission to act which results in death, and accompanied by the necessary *mens rea* will only give rise to criminal liability in those specified circumstances where the criminal law imposes a legal duty to act.

In contrast to the common law's expansive approach to positive acts of harm, there has traditionally been a reluctance to impose criminal liability for omissions to prevent harm.⁶⁷ It has been suggested that the basis of this distinction between acts and omissions is to be found in the belief that the function of the criminal law was the prevention of positive harm, and that encouragement of good deeds should be left to public opinion, morality and religion.⁶⁸ In addition, a number of practical reasons have been put forward to explain the differential approach of the common law to acts and

⁶⁴ President's Commission Report, 65.

⁶⁵ Consideration of the allocation of scarce resources is beyond the scope of this thesis.

⁶⁶ As previously noted, there is an ongoing debate as to whether some forms of discontinuation of treatment (such as the removal of artificial life-support) which involve active interventions should be classified as an 'act' or an 'omission'. This fundamental question is dealt with in chapter IV, 150-163.

⁶⁷ For a critical analysis of the conventional view with respect to liability for omissions, see A. Ashworth, 'The Scope of Criminal Liability for Omissions' (1989) 105 *Law Q.Rev.* 424.

⁶⁸ Smith and Hogan, 43.

omissions. First of all, there are very real difficulties in attributing blame for omissions as distinct from acts. If there is an act, someone acts, but if there is an omission, everyone (in a sense) omits.⁶⁹ The difficulty is that in the case of omissions, there are too many potential candidates for liability.⁷⁰ Consequently, there has been a natural tendency to accord criminal responsibility only in circumstances where there is some special relationship or situation of control which is seen as giving rise to a legal obligation to act to prevent harm. Second, as Williams points out, it is harder for the general public to learn and remember a law about harmful omissions than it is to learn and remember a law about harmful acts.⁷¹ Whilst ordinary persons can readily understand that they are required not to cause harm to others, they will rarely properly comprehend the circumstances in which they must aid others.

Another, more substantive, explanation for the reluctance of the common law to impose liability for an omission to act is that the imposition of a duty to act is an interference with the liberty of a person who wishes only to mind his or her own business and let others get on with minding theirs.⁷² Whilst most people are capable of *refraining* from causing harm, the *prevention* of harm is likely to be more demanding. This point is well made by Williams, when he expresses the view that:

You can refrain from doing something simply by refraining; but you cannot perform a duty to act without, often, going to considerable trouble, inconvenience, expense and perhaps even danger.⁷³

It has also been argued that omissions do not *cause* evil results in the same obvious sense that acts do.⁷⁴ The reasoning employed here is that since the defendant does nothing, the evil result would necessarily occur in precisely the same way if, at the moment of the alleged omission, the defendant did not exist.⁷⁵ This causation issue, and the attitude of the common law regarding omissions generally, is well illustrated in the oft cited example found in *Stephen's Digest of the Criminal Law*⁷⁶ of the passer-by who sees a child drowning in a shallow pool. The passer-by could easily save the child without risk to himself, but allows the child to drown. At common law he commits no offence since he did not drown the child. If he had not come along the child would have drowned in just the same way.

Thus, because of the special nature of omissions to prevent harm, the common law has rarely imposed criminal liability in respect of such conduct, and a duty to act will only arise in certain defined circumstances. A similar position has been adopted in those jurisdictions where the criminal law has been codified. Under the *Crimes Act 1900* (N.S.W.), liability for murder as a result of an

⁶⁹ Williams, *Textbook of Criminal Law*, 148. See also Fletcher, 1009-1010.

⁷⁰ Fletcher, 1009-1010.

⁷¹ G. Williams, 'What Should the Code do About Omissions?' (1987) 7 *Legal Stud.* 92, 93.

⁷² J.C. Smith, 'Liability for Omissions in the Criminal Law' (1984) 4 *Legal Stud.* 88. See also Ashworth, 427-429.

⁷³ Williams, 'What Should the Code do About Omissions?', 93.

⁷⁴ Smith, 88; B. Hogan, 'Omissions and the Duty Myth' in P. Smith, (ed.) *Criminal Law* (1987) 85.

⁷⁵ Smith, 88.

⁷⁶ (5th ed., 1894) Article 212.

omission will only lie where, in accordance with basic common law principles governing criminal liability in respect of an omission, the defendant was under a legal duty⁷⁷ to act to prevent death, and omitted to do so, whilst concurrently possessing the necessary *mens rea*. It is also clear from the statutory scheme under the Australian Criminal Codes that criminal liability for an omission to act will not be established in the absence of a legal duty to act.⁷⁸ Each of the Codes specifies the duties of care to which one must conform in the preservation of human life⁷⁹ and imposes criminal liability for the consequences to life or health of an omission to perform those duties.⁸⁰ At both common law and under the Codes, where a duty to act can be established, the omission of that duty by a person obligated to act has the same effect in law as an act that produced the same result.⁸¹

From the foregoing discussion it is clear that in all Australian jurisdictions, criminal liability for omissions will only be established in circumstances where there is a pre-existing legal duty to act. It is therefore necessary to examine the circumstances in which a legal duty to act can be established.

The Imposition of a Legal Duty to Act

As a result of the law's cautious attitude to omissions there has been a marked reluctance to impose legal duties, breach of which give rise to criminal liability. The law has generally required the existence of some kind of special relationship between the parties before a duty to act arises.⁸² One such special relationship which has been held to give rise to a legally recognised duty to act is that of doctor and patient. The relationship between doctor and patient is basically contractual, arising from an offer and acceptance.⁸³ The contract may arise as a result of an express agreement, or, more usually, it may be implied from the conduct or circumstances of the parties. A prospective patient may come to the doctor, seeking to obtain the doctor's services. The doctor is then free to either accept or reject the patient's offer.⁸⁴ If the offer is accepted, a contract comes into existence and the law imposes a duty on the doctor to continue treatment as long as the case requires, in the absence of

⁷⁷ P. Gillies, *Criminal Law* (2nd ed., 1990) 598.

⁷⁸ J.M. Herlihy and R.G. Kenny, *An Introduction to Criminal Law in Queensland and Western Australia* (3rd ed., 1990) 177.

⁷⁹ N.T. ss. 149-153; Qld. ss. 285-290; Tas. ss. 144-151, 156(2)(b); W.A. ss. 262-267.

⁸⁰ N.T. s. 153; Qld. ss. 285-290; Tas. s. 152; W.A. ss. 262-267. (Note, however, that the duty provisions in the various Australian Criminal Codes do not in themselves create offences; see Herlihy and Kenny, 89.) Note also ss. 215-218 of the Canadian *Criminal Code* 1985; ss. 151-157 of the New Zealand *Crimes Act* 1961.

⁸¹ Skegg, 'The Termination of Life-Support Measures and the Law of Murder,' 424 and the President's Commission Report, 34.

⁸² Williams, *Textbook of Criminal Law*, 150.

⁸³ I. Kennedy and A. Grubb, *Medical Law* (1989) 129. Note, however, their view that the relationship between doctor and patient within the National Health Service is probably not contractual in nature because there is a statutory duty to provide services; Kennedy and Grubb, 98.

In circumstances where a patient enters a hospital, the patient contracts with both the hospital and the treating doctor. In countries which have a national health care scheme and the patient does not actually have to pay for health care, questions may arise regarding the legal requirement of consideration. It is arguable, however, that simply submitting to treatment is a sufficient detriment which could serve as consideration; see E. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2nd ed., 1984) 32.

⁸⁴ A doctor is not obliged to treat all comers; see Baugham, Bruha and Gould, 1207 and reference to the case of *Findlay v Board of Supervisors* 72 Ariz. 58 (1951).

an agreement to the contrary.⁸⁵ A doctor cannot abandon his or her patient by purporting to terminate the contractual relationship without allowing the patient to make alternative arrangements.⁸⁶ Even in the absence of a contractual duty to provide medical care, a duty may yet arise if it can be established that the doctor has voluntarily assumed or undertaken the care of a patient.⁸⁷ Once a duty situation is found to be in existence as in the case of the doctor/patient relationship, the various legal duties which exist at common law and in Code jurisdictions come into play. In all Australian jurisdictions, there are two legal duties which may be of particular relevance to the liability of a doctor for withholding or withdrawing treatment; the duty to provide the 'necessaries of life', and the duty to do acts undertaken, the omission of which would be dangerous to human life.⁸⁸ Consideration will now be given to these two legal duties.

The Duty to Provide the Necessaries of Life

The duty to provide the necessaries of life exists both at common law and under the Australian Criminal Codes.⁸⁹ The law imposes a duty to provide necessaries in circumstances where a person has charge of another who is unable to provide him or herself with the necessaries of life by reason of some infirmity or condition, for example, due to age, sickness or unsoundness of mind. Under s. 146 of the Tasmanian Code, necessaries of life are specified to include medical and surgical aid and medicine. Whilst no equivalent provision exists in the Queensland, Western Australian or Northern Territory Codes, the courts have interpreted necessaries of life to include medical aid and treatment for the purpose of establishing liability under the Codes.⁹⁰ A similar view has been taken at common law.⁹¹ There has, however, been no exhaustive statement, either at common law or for the purposes of the Codes of the meaning of the phrase 'necessaries of life' and the kinds of medical treatment that it covers. It is, for example, not clear whether the duty to provide the necessaries of life would automatically extend to all forms of artificial life-support such as respirators, dialysis and artificial nutrition and hydration. One view, which has considerable merit, is that the scope of the doctor's duty would depend on the circumstances of the case and on the question whether the failure to provide medical treatment was reasonable in the circumstances.⁹²

⁸⁵ Baugham, Bruha and Gould, 1207 referring to the case of *Ricks v Budge* 64 P. 2d 208, 211 (1937).

⁸⁶ Baugham, Bruha and Gould, 1208 citing *Murray v United States* 329 F. 2d 270, 272 (1964).

⁸⁷ For example, *R v Instan* [1893] 1 Q.B. 450; *R v Stone* [1977] 1 Q.B. 354. Note, however, the view of H. Beynon, 'Doctors as Murderers' (1982) *Crim.L.Rev.* 17, 24-25 that this category does not encompass doctors since the cases in support of it either concerned relatives or persons having some financial incentive for providing services.

⁸⁸ Note also the potential relevance of the additional duties contained in the Northern Territory *Criminal Code*; see ss. 154-155.

⁸⁹ N.T. s. 149; Qld. s. 285; Tas. s. 144; W. A. s. 262. Note also s. 215 of the Canadian *Criminal Code* 1985; s. 151 of the New Zealand *Crimes Act* 1961.

⁹⁰ *R v McDonald* [1904] St. R. Qd. 151. (The common law duties continue to be relevant in New South Wales and the Australian Capital Territory for the purposes of liability for murder by omission under the *Crimes Act* 1900 (N.S.W.).)

⁹¹ *R v Brooks* (1902) 5 C.C.C. 372; *Oakey v Jackson* [1914] 1 K.B. 216.

⁹² For example, P. MacFarlane, 'Death and Dying,' paper presented at the Australian Medico-Legal Conference, 22 Sept. (1990) 9. Note also B. Dickens, 'The Right to Natural Death' (1981) 26 *McGill L.J.* 847, 871; P. Gerber and A. Vasta, 'Criminal Law' (1984) 58 *A.L.J.* 291, 295. This was the view taken in a recent New Zealand case involving a patient who had virtually no brain function (although not actually brain dead) and who ventilator dependent. Justice Thomas of the Auckland High Court, in interpreting s.151 of the New Zealand *Crimes Act* 1961, said that the question whether a ventilator should be regarded as a necessary of life must depend on the facts of each case. Thus, it may be regarded as a necessary of life where it is required to prevent, cure or alleviate a disease that endangers the health

Before the duty to provide a patient with medical treatment and other necessities of life can arise, the doctor must 'have charge' of the patient. Whether a person has charge of another is a question of fact. A patient may be under a doctor's charge as a result of a contract or some other relationship. Thus, doctors, who have contracted to care for someone who is helpless by reason of age or illness, have a duty to provide that person with necessary medical treatment. Alternatively, in the absence of contract, if a doctor has otherwise undertaken the care of a patient, the law imposes an obligation to provide that patient with necessary medical treatment.

Where a doctor is under a legal duty to provide a patient with the necessities of life including medical treatment, the doctor will be held criminally liable for any consequences which result to the life or health of the patient by reason of the doctor's omission to perform that duty, provided the requisite *mens rea* is established.⁹³ If a patient dies as a result of the doctor's deliberate breach of that duty, the doctor could be charged with murder at common law and under the Codes.

The Duty to Do Acts Undertaken

Both at common law and under the Codes, a duty is imposed to do acts undertaken, the omission of which may be dangerous to human life. The relevant provision in the Queensland and Western Australian Criminal Codes reads as follows:

When a person undertakes to do any act the omission to do which is or may be dangerous to human life or health, it is his duty to do that act and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty.⁹⁴

Although the duty under the Codes is similar to that imposed at common law, it is slightly wider in that it extends to acts undertaken, the omission of which may be dangerous to *human life or health*, whereas the common law duty is restricted to acts which may be dangerous to *human life*. The duty to do acts undertaken clearly applies to a medical practitioner who has undertaken to provide treatment,

or life of the patient. If, however, the patient is surviving only by the mechanical means the provision of a ventilator cannot properly be construed as a necessary of life. In Mr L's case there was no prospect of improvement and Justice Thomas held that in these circumstances, it served no purpose and could not properly be regarded as a necessary of life; *New Zealand Herald* 28 Aug. 1992.

Some indirect support for this view can also be gleaned from the Canadian case of *Nancy B. v Hotel-Dieu de Quebec et al* 69 C.C.C. (3d) (1992) 450, 458. Although essentially a civil case concerning the right of a competent patient to direct that a life-sustaining respirator be removed, the Quebec Superior Court also examined the criminal law implications of a doctor's compliance with the patient's request. In examining the relevant sections of the Canadian *Criminal Code* the court was of the view that s. 217 (dealing with the duty of persons undertaking acts) potentially applied. No reference was made to s. 215 dealing with the duty to provide necessities of life. This could be taken to suggest that the court did not think that the provision of artificial life-support was a 'necessary of life'. For further discussion see chap II, 78-79.

⁹³ For the position under the Codes, see N.T. s. 153; Qld. s. 285; Tas. s. 152; W.A. s. 262. Note also s. 215 of the Canadian *Criminal Code* 1985; s. 151 of the New Zealand *Crimes Act* 1961.

⁹⁴ Qld. s. 290; W.A. s. 267. The provisions in the Codes of other Australian jurisdictions are in similar terms; N.T. s. 152; Tas. ss. 151 and 152. Note also s. 217 of the Canadian *Criminal Code* 1985; s. 157 of the New Zealand *Crimes Act* 1961.

(for example, artificial life-support) the omission of which would be dangerous to the life or health of the patient.⁹⁵

The Causation Requirement

As we have seen, a doctor may be liable under the criminal law not only for his or her acts which result in death, but also for omissions, in circumstances where there was a duty to act. For the purposes of the present discussion it will be assumed that the doctor was under a duty to provide treatment to the patient, and his or her failure to do so was accompanied by the requisite *mens rea* for the crime of murder. In addition to these elements, in order for criminal liability for murder to be established against the doctor, it will also be necessary to prove that the failure to provide treatment was causally connected with the death of the patient. In the majority of homicide cases, there is little doubt as to the cause of death of the victim, and consequently, the issue of causation does not specifically arise.⁹⁶ Occasionally, however, difficult problems of causation do occur and one particular area where this issue may gain prominence is in the context of omissions.

Omissions as a Cause of Death

An initial objection may be raised that an omission cannot in any real sense be a cause of death.⁹⁷ Since the person has simply omitted to act, the death would have occurred in precisely the same way if, at the moment of the alleged omission, he or she did not exist.⁹⁸ On this view, the death can readily be attributed to factors other than the non-intervention of the person omitting to act. Thus, in the medical context, where certain treatment or procedures have been withheld or withdrawn from a terminally ill patient, it is easy to attribute the cause of death to the underlying condition or disease of the patient rather than the failure of the doctor to intervene.⁹⁹ However, as Williams observes, whatever the philosophical view may be, the courts certainly assume and must assume that an omission can be a cause of death. Whilst it may be easier to find the causation requirement established in a situation where a doctor has taken active steps to kill his or her patient, circumstances can be readily envisaged where the death of the patient was clearly caused by the *omission* of the doctor to provide necessary treatment. Take, for instance, a situation where an otherwise healthy patient, who desired treatment, dies from untreated pneumonia. In these circumstances, the doctor's failure to provide the necessary treatment could fairly be taken to have *caused* the death of the patient.¹⁰⁰

⁹⁵ This proposition is supported by the Canadian case of *Nancy B. v Hotel-Dieu de Quebec et al* 69 C.C.C. (3d) (1992) 450; see above, n. 92.

⁹⁶ Williams, *Textbook of Criminal Law*, 379-380, Fisse, 30.

⁹⁷ For example, Fletcher, where he develops the argument that in certain circumstances, an omission which involves the interruption of life-sustaining therapy, such as turning off a mechanical respirator, is not a cause of death. See also Smith, 88; Hogan, 85-91.

⁹⁸ Smith, 88.

⁹⁹ See the discussion in the President's Commission Report, 68-70 where it is pointed out that the identification of the cause of death inevitably involves a normative question of attributing responsibility. In circumstances where a patient dies following non-treatment, the designation of the patient's underlying disease as the cause of death indicates not only that a fatal disease process was present, but also communicates acceptance of the doctor's conduct in forgoing treatment.

¹⁰⁰ *Id.* 69-70.

Omissions to Provide Treatment Resulting in the Death of the Patient

As was noted earlier, both at common law and under the Codes, there are two distinct aspects to the legal principle of causation; the *sine qua non* test and the issue of imputability.¹⁰¹ Under the *sine qua non* or 'but for' test, it is necessary to establish that, as a matter of fact, the doctor's conduct caused the death of the patient although it need not be the sole or the main cause of death.¹⁰² This will be a question of fact in each case, and must be established by the prosecution beyond reasonable doubt. As Williams comments, the application of the usual burden of proof to the issue of causation is of considerable practical importance in the case of omissions¹⁰³ and often results in unsuccessful prosecutions.¹⁰⁴ Thus, it would have to be shown beyond reasonable doubt that, had the doctor not withheld or withdrawn treatment, the patient would not have died at that time and in that way. From a practical point of view, it may be difficult to determine the factual cause of the patient's death with any accuracy. In some instances, it will be relatively easy to establish that the cause of the patient dying, at that time and in that manner, was due to the withholding or withdrawing of treatment; for example, a diabetic patient requiring insulin or an accident victim requiring a blood transfusion. However, in the context of terminally ill patients who are in any event close to death, difficulties may arise in establishing beyond reasonable doubt that the death was due to the omission and not the patient's underlying condition.¹⁰⁵

In addition to the *sine qua non* test it will also be necessary to show that the doctor's conduct was an imputable or legal cause of the patient's death. The imputable cause component of the causation test is by its nature, incapable of strictly objective assessment. Essentially it involves determination of whether the doctor's conduct is sufficiently connected with the death of the patient so as to attribute to him or her legal responsibility for that death. In circumstances where a patient has died following non-treatment, the court will need to weigh up the factors leading to the death of the patient to determine the significance of the doctor's contribution in withdrawing treatment, and whether legal responsibility for the death should, as a matter of law, be attributed to the doctor. Whilst the involvement in the cause of death need not be substantial to render a defendant guilty of murder,¹⁰⁶ a very minimal or trivial contribution to the cause of death may be ignored under the *de minimus* principle.¹⁰⁷ The court may find that although the withholding or withdrawal of treatment contributed to the patient dying at that time and in that manner, the contribution was so minimal or negligible in light of the patient's terminal condition that it should be disregarded. Whether there is

¹⁰¹ See above, 13.

¹⁰² Smith and Hogan, 278.

¹⁰³ *Textbook of Criminal Law*, 380.

¹⁰⁴ See Hughes, 627-631 for criticism of this rule on the ground that it is inappropriate in the case of homicide by omission, because it allows too easy a let-out for the accused.

¹⁰⁵ Williams, 'What Should the Code do About Omissions?' 106 where he notes that doctors will often testify that their ministrations would probably have saved the sufferer, but are unlikely to swear that they could, beyond reasonable doubt, have saved him.

For a case law example of difficulties which may be encountered in establishing causation, see *R v Arthur* (unreported) *The Times*, 6 Nov. 1981.

¹⁰⁶ *R v Cato* [1976] 1 All E.R. 260, 265-266.

¹⁰⁷ See above, 14.

sufficient evidence to support a finding of imputable cause is a question of law for the determination of the court. Ultimately, it remains a value judgment whether the result can fairly be said to be imputable to the defendant.¹⁰⁸ If the court is of the opinion that there is sufficient evidence to support such a finding, the question of the defendant's guilt or innocence will be left to the jury.¹⁰⁹

A number of criminal law cases involving the withdrawal of treatment from victims of assault suggest that the courts may be reluctant to attribute the death of a patient to the conduct of the doctor.¹¹⁰ In these cases the courts have held that the discontinuance of life-support from a brain-damaged assault victim does not break the chain of causation between the initial injury and the death and therefore did not constitute the relevant cause of death. These cases lend support to the view that withholding treatment is sometimes a sound medical decision and in some circumstances will not constitute a cause of death.¹¹¹

Special note should also be made of the position in South Australia pursuant to the *Natural Death Act* 1983 (S.A.). Although the principal object of this legislation is to give effect to the written directions of a patient that he or she does not wish to receive certain medical treatment if he or she becomes terminally ill,¹¹² the exculpation provision contained in the Act has a potentially much wider application. Section 6(1) provides that:

For the purposes of the law of this State, the non-application of extraordinary measures to, or the withdrawal of extraordinary measures from, a person suffering from a terminal illness does not constitute a cause of death.

The effect of this section would be to allow a doctor to withhold or withdraw extraordinary measures from a patient who is terminally ill, irrespective of whether or not the patient has executed an advance directive under the legislation. If the patient subsequently dies, the illness, and not the withholding or withdrawal of treatment, would constitute the relevant cause of death.¹¹³ Significantly, the Northern Territory *Natural Death Act* 1988, which is largely modelled on the South Australian legislation does not contain such an expansive provision.¹¹⁴

¹⁰⁸ See above, 13.

¹⁰⁹ Fisse, 33.

¹¹⁰ See, for example *R v Malcherek* [1981] 1 W.L.R. 690; *R v Kinash* [1982] Qd.R. 648; and the discussion in Z. Lipman, 'The Criminal Liability of Medical Practitioners for Withholding Treatment from Severely Defective Newborn Infants' (1986) 60 *A.L.J.* 286, 289.

¹¹¹ Lipman, 289.

¹¹² See chapter VII, 294-297.

¹¹³ For an analysis of this provision, see D. Lanham and B. Fehlberg, 'Living Wills and the Right to Die With Dignity' (1991) 18 *Melbourne U.L.Rev.* 329, 348-349.

¹¹⁴ See s. 6(1) *Natural Death Act* 1988 (N.T.) which makes it clear that the scope of the provision is limited to circumstances where the non-application or withdrawal of extraordinary measures was as a result of and in accordance with the patient's direction, made under the legislation.

Mens Rea for the Crime of Murder

In order to establish criminal liability for murder by omission, the *actus reus* for that crime, (the failure to perform a legal duty which causes the death of the victim,) must be accompanied by the requisite *mens rea* for the crime of murder. It is therefore necessary to consider the *mens rea* for the crime of murder and its application in circumstances in which a doctor omits to provide medical treatment and the patient dies as a result.¹¹⁵ As a result of certain differences in the law regarding the *mens rea* for murder as between common law and Code jurisdictions, separate consideration will be given to the law in these respective jurisdictions.

Common Law Position

The common law position regarding the mental element for murder in Australia has been unequivocally stated by the High Court in *R v Crabbe*.¹¹⁶ The requisite mental element can be established by evidence of either an *intention* to cause death or grievous bodily harm or, in the absence of actual intention, *knowledge* that death or grievous bodily harm was the *probable* or *likely* consequence of that conduct.¹¹⁷ The High Court was of the view that this conclusion regarding the mental element for murder was not only supported by the preponderance of authority but was also sound in principle.¹¹⁸ A person who does an act *knowing* that death or grievous bodily harm is a *probable* or *likely* consequence, can be regarded for the purposes of the criminal law as just as blameworthy as a person who does an act *intending* those consequences to occur.¹¹⁹

In the medical context, it is not difficult to accept the possibility that a doctor may omit certain treatment with the intention of causing the death of the patient so as to relieve the patient of prolonged suffering. However, it may appear incongruous to suggest that a *bona fide* doctor could intend to cause a patient grievous bodily harm by his or her omission. As unlikely as it may seem, this possibility cannot be ruled out. It is conceivable that certain treatment may be withheld or withdrawn with the intention of not actually causing the death of the patient, but of diminishing the patient's defences, and thereby leaving the patient more susceptible to the process of death.

On the basis of the principles propounded by the High Court in *R v Crabbe*, it would appear that the prosecution would have little difficulty in establishing the necessary mental element for murder in respect of a doctor who has deliberately withheld or withdrawn life-sustaining medical treatment from

¹¹⁵ It should be noted that even if the necessary intention for the crime of murder cannot be established, a doctor may still face charges of criminal negligence. However, as noted earlier, this thesis is concerned with conduct deliberately undertaken at the request of a patient. Consideration of the law with regard to manslaughter is therefore beyond its scope.

¹¹⁶ (1985) 58 A.L.R. 417.

¹¹⁷ *Id.* 421. As the mental element for murder under the *Crimes Act* 1900 (N.S.W.) mirrors the position at common law the following discussion is also relevant for the purposes of New South Wales. See also s. 12(1) *Crimes (Amendment) Ordinance (No. 2)* 1990 (A.C.T.) which has, for the purposes of the law in the Australian Capital Territory, modified the operation of the *Crimes Act* 1900 (N.S.W.).

¹¹⁸ *Id.* 420.

¹¹⁹ *Ibid.*

a patient. The acceleration of the patient's death would generally be the intended result, or if not intended, certainly death or grievous bodily harm would be within the (actual) knowledge of the doctor as the *probable* or *likely* result of the withholding or withdrawing of medical treatment. Further, note should be taken of an *obiter* statement in *Crabbe's* case that knowledge of a *possible* (as distinct from *probable*) result might be enough to establish murder if the act is done with the intention and for the sole purpose of creating a risk of death or grievous bodily harm.¹²⁰ It has been suggested that this situation could be applicable to doctors who cease treatment, since the reason for withdrawing or withholding treatment may be to create a situation in which the patient may die more quickly and with less suffering.¹²¹

Position Under the Codes

As outlined earlier, in all Australian Code jurisdictions, the mental element for murder includes an intention to cause death or grievous bodily harm.¹²² Accordingly, if there is evidence that the doctor actually *intended* to cause the death of the patient or cause the patient grievous bodily harm by the withholding or withdrawing of medical treatment, the *mens rea* for murder could readily be established. In most of the Australian Criminal Codes, there is no provision corresponding to the common law category of *knowledge* or foreseeability that death or grievous bodily harm is a *probable* or *likely* consequence.¹²³ The relevant provisions refer only to an *intention* to cause death or grievous bodily harm.¹²⁴ However, where there is evidence that the doctor *knew* that death or grievous bodily harm was a probable or likely consequence of the withholding or withdrawing of treatment, it would not be difficult to find that the doctor actually *intended* that result.¹²⁵

Of all the Australian Criminal Codes, the Tasmanian Code provision with regard to the mental element for murder most closely approximates the common law. Under s. 157(1)(b) of the Tasmanian *Criminal Code* 1924, in addition to the intentional causing of death, the *mens rea* for murder can be established in circumstances where the defendant intended to cause bodily harm which he or she knew to be likely to cause death in the circumstances. The High Court has interpreted the phrase 'knew to be likely to cause death' as being synonymous with knowledge of the probability that death would result.¹²⁶ To this extent, this provision of the Tasmanian Code is equivalent to the common law position as expounded by the High Court in *R v Crabbe*. The Tasmanian provision is, however, narrower than the common law by virtue of the requirement under s. 157(1)(b) that the offender must intend to cause bodily harm to the person killed. Thus, in the medical context, if a doctor, in breach of his or her legal duty, omits to provide life-sustaining medical treatment intending to cause bodily

¹²⁰ *Id.* 420-421.

¹²¹ D. Mortimer, 'Criminal Responsibility for Cessation of Medical Treatment' (unpublished Honours thesis, Law Library, Monash University, 1986) 26.

¹²² See above, 12. Grievous bodily harm is defined in the Codes; for example in s. 1 of the Tasmanian *Criminal Code*, it is defined as 'any bodily injury of such a nature as to endanger or be likely to endanger life, or to cause or be likely to cause serious injury to health'.

¹²³ The only exception is the Tasmanian *Criminal Code* discussed below.

¹²⁴ For example, N.T. s. 162; Qld. s. 302; W.A. s. 279.

¹²⁵ *R v Wilmot* [1985] 2 Qd. R. 413, 418.

¹²⁶ *Bouhey v R* (1986) 65 A.L.R. 609.

harm which he or she knew to be likely to cause death, the necessary *mens rea* for murder will be established under the criminal law as applying in Tasmania.

Irrelevance of Motive and the Terminal Condition of the Patient.

As was observed during the earlier discussion regarding the criminal liability of doctors for acts which cause the death of the patient, provided the necessary *mens rea* for the crime of murder is established, the motive of the doctor is irrelevant. Thus, if the doctor's omission to provide a patient with medical treatment involves the *actus reus* and *mens rea* for murder, it will be irrelevant to the question of liability that the doctor acted out of compassionate and *bona fide* motives. Further, the fact that the patient in respect of whom treatment was withheld or withdrawn was in a terminal condition, and would in any event have soon died, does not alter the criminal liability of the doctor. Any acceleration of death will suffice, provided only that it is not so minimal or trivial as to be disregarded under the *de minimus* principle.

Conclusion

The object of this chapter has been to examine the present state of the criminal law regarding the practice of active and passive euthanasia in Australia with the aim of ascertaining the potential liability of doctors for participation in these practices.

It has been demonstrated that the practice of active euthanasia, even where performed at the request of a patient, constitutes murder. If a doctor, at the request of his or her patient, performs an act which causes death, the doctor is potentially liable for murder. For the purposes of establishing criminal liability for acts causing death, no account is taken of the special nature of the doctor/patient relationship, the fact that the acts causing death were performed at the request of the patient, or that they were performed by a doctor acting *bona fide*, out of the highest motives. Moreover, the fact that the patient was in a terminal condition and death was in any event imminent would also be irrelevant.

It has also been shown that passive euthanasia may attract criminal liability. As a result of the special duty owed by doctors to their patients, a doctor who deliberately withholds or withdraws treatment from a patient with the intention of facilitating the patient's death or in the knowledge that this would probably result, is potentially liable for murder if the patient's death in fact results from that omission. Whether or not a doctor is liable in these circumstances will depend on the scope of the doctor's duty to his or her patient. It is to this question which attention must now turn.

CHAPTER II

THE PATIENT'S RIGHT TO REFUSE TREATMENT

Introduction

The analysis in the foregoing chapter of a doctor's potential liability for passive euthanasia has been predicated on the premise that a doctor is, in certain circumstances, under a legal duty to provide treatment to his or her patient. As was previously emphasised, an omission to act which results in death will only give rise to criminal liability in circumstances where there is a legal duty to act. Crucial therefore to the question of a doctor's criminal liability for passive euthanasia is the scope of the doctor's duty to his or her patient. For the purposes of this thesis, particular attention will be focussed on the legal effect of a patient's refusal of treatment upon the doctor's duty to provide treatment.

As was demonstrated in chapter I, both at common law¹ and under the Codes, doctors are, in certain circumstances, under a legal duty to provide their patients with medical treatment and the failure to do so may be a culpable omission for the purposes of the criminal law.² If a patient dies as a result of the doctor's deliberate omission in providing necessary medical treatment which is reasonably available, the doctor may be found criminally liable for murder.

However, the fact that doctors have a legal duty to provide medical treatment to their patients does not mean that *every* omission to provide life-prolonging treatment is a culpable omission for the purposes of the law of homicide. Whether a doctor is criminally liable for an omission which causes death depends upon the *scope* of the doctor's professional duty towards his or her patient. It is generally accepted that a doctor's duty to his or her patient is not absolute.³ The law does not require that *all* possible treatments and procedures be used in every case. The patient's prognosis may be so poor that

¹ Also under the *Crimes Act* 1900 (N.S.W.) which relies upon general common law principles regarding legally recognised duties to act.

² See chapter I, 22-30.

³ G. Williams, *Textbook of Criminal Law* (2nd ed., 1983) 279-282; H. Beynon, 'Doctors as Murderers' (1982) *Crim.L.Rev.* 17, 25; A. Dix *et al*, *Law for the Medical Profession* (1988) 298-300. There have also been a number of cases (albeit in the civil jurisdiction) where the courts have indicated that the termination of life-sustaining treatment would in some circumstances, not be unlawful; see, for example, the famous *In re Quinlan* 355 A. 2d 647, 669-670 (1976) (see discussed below, 46, 52-53) and the cases involving defective newborns; see *In re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 W.L.R. 1421, 1422; *In re C (A Minor) (Wardship: Medical Treatment)* [1989] 3 W.L.R. 240; *In re J (A Minor) (Wardship: Medical Treatment)* (1991) 2 W.L.R. 140. However, these latter English cases have involved the court's wardship jurisdiction and are therefore not decisive of the circumstances in which the criminal law imposes a duty on doctors. In a wardship case, the court can only act in the best interests of the child, and therefore the future prospects for the child will almost inevitably be the sole criterion, but in criminal cases, other factors may be relevant. See also Beynon, 26.

the continuation of treatment is futile, and the artificial prolongation of the dying process may in fact be seen as being contrary to the patient's best interests. In such circumstances, where the patient is unlikely to benefit from further treatment, a doctor would not be under a legal duty to provide that treatment.⁴ Furthermore, in view of the practical limitations on the availability of medical resources, some consideration of the appropriate allocation of scarce resources and of cost-effectiveness inevitably must come into the decision-making.⁵ Especially in light of the general ageing of our population, the demand for medical resources could not be met if every possible measure was obligatory in all cases. Whilst there is widespread agreement that there are limits on the duty of doctors to treat terminally ill patients, the difficulty lies in determining the precise *scope* of that duty and at what point the doctor's duty ceases. This has resulted in a considerable amount of uncertainty about the extent of a doctor's duty to provide medical treatment to his or her patient and what omissions will amount to a dereliction of duty. There is very real concern amongst many health care professionals about their potential legal liability for the withholding or withdrawing of treatment from a patient.⁶ This state of uncertainty obviously has undesirable consequences for medical practice as doctors may, for fear of criminal liability, be reluctant to withhold or withdraw treatment where it would otherwise be appropriate to do so. In turn, the continuation of futile medical treatment is unlikely to promote the interests of patients.

In an attempt to clarify the nature and extent of a doctor's duty to his or her patient, a number of different formulations have been advanced.⁷ It is, however, not intended to embark here upon a general examination of the precise scope of a doctor's duty to provide treatment. The purpose of this part is to pursue a more limited line of inquiry; to confine analysis to circumstances where a doctor is under a *prima facie* duty to treat, and then to focus attention on the position of a patient with decision-making capacity, who has given a clear direction that he or she wishes to have no further treatment, and to examine the legal implications of such a direction upon the doctor's legal duty to provide treatment.

Situations may arise where a doctor has in his or her care a patient with decision-making capacity, for whom certain life-prolonging or even life-saving measures would be available, but the patient may request that no further treatment be administered.⁸ Since a doctor will not be criminally liable for an

⁴ This would be the case regardless of whether the patient wishes to receive that treatment: whilst a patient has a right to *refuse* treatment he or she cannot insist upon receiving all possible medical treatment against the medical judgement of the doctor; I. Kennedy, *Treat Me Right* (1988) 321. For an American case which raised this issue in a civil context see *In re Helga Wanglie* Fourth Judicial District (Dist. Ct. Probate Ct. Div.) PX-91-283, Minnesota, Hennepin County. For discussion of this case see M. Angell, 'The Case of Helga Wanglie' (1991) 325 *New Eng.J.Med.* 511; and S. Miles, 'Informed Demand for Non-Beneficial Treatment' (1991) 325 *New Eng.J.Med.* 512.

⁵ See National Health and Medical Research Council, *Discussion Paper on the Ethics of Limiting Life-Sustaining Treatment* (1988) 15.

⁶ For example, Parliament of Victoria Social Development Committee, Second and Final Report *Inquiry into Options for Dying with Dignity* (1987) 43-48 (hereafter referred to as Victorian Social Development Committee Report); Law Reform Commission of Western Australian, Project No. 84, Report, *Medical Treatment for the Dying* (1991) 4.

⁷ For example, a duty based upon professional standards and customary practice or a duty dependent on the contract pursuant to which the doctor provides medical treatment. For discussion, see Beynon, 23-28.

⁸ The patient may refuse *all* further treatment or may selectively refuse treatment; for example, declining certain life-prolonging treatment but accepting nutrition and hydration and treatment for pain management.

omission to treat unless he or she is under a legal duty to provide treatment, the fundamental question which arises for determination is the legal effect of the patient's refusal of treatment upon the doctor's duty to treat. Resolution of this question involves consideration of the interrelationship between two disparate and potentially conflicting areas; the patient's common law right to refuse treatment and the criminal law position regarding the legal status of consent of the victim in determining culpability for homicide. In turn, these issues reflect wider interests and competing considerations; the individual's interest in patient autonomy and self-determination on the one hand, and the State's interest in the preservation of human life on the other.

In the discussion which follows, it will be argued that in circumstances where a patient refuses treatment, a doctor is no longer under a legal duty to provide that treatment to the patient and is in fact required by law to comply with the patient's wishes. In the absence of a legal duty to provide treatment, failure to do so is not a culpable omission for the purposes of the criminal law and will not give rise to criminal liability, even though the patient's death may result. Thus, a patient who directs that life-sustaining treatment be withheld or discontinued is not consenting to a crime, but simply exercising his or her right to refuse treatment.

This chapter is divided into two parts; part I dealing with the patient's common law right to refuse treatment, and part II examining the legal effect of this right upon a doctor's duty to provide treatment.

PART I

The Patient's Common Law Right to Refuse Treatment

Introduction

Whilst there is not much direct authority in support of the common law right of a patient to refuse treatment in either Australia or the United Kingdom,⁹ there is little room for doubt that the principles of bodily integrity and self-determination which underlie that right apply in these jurisdictions. Because of the dearth of direct authority in these jurisdictions regarding the right of a patient to refuse treatment, it is necessary to resort to basic common law principles in support of the existence of this right.

The common law has long recognised an individual's right to self-determination over his or her own body, free from interference by others.¹⁰ This right of self-determination is said to express the

⁹ The same holds true for New Zealand. There is, however, a growing body of case law in Canada and of all jurisdictions, the patient's right to refuse treatment has been most frequently litigated in the United States. (The position in the United States is dealt with separately below, 45-68.)

¹⁰ T. Engelhardt, *The Foundations of Bioethics* (1986) 264 where he states that it is one of the presumptions of English law that individuals should be secure in their bodies against the unauthorised touching of others. See also *Union Pacific Railway v Botsford* 141 U.S. 250, 251 (1891) where the court stated 'no right is more sacred or is more carefully guarded, by the common law, than the right of

principle, or value choice, of autonomy of the person.¹¹ Central to this right to bodily integrity is the common law doctrine of consent. Strictly speaking, every unauthorised touching of a person constitutes an assault and battery¹² and it is only the fact of consent which renders it lawful.¹³ Consequently, in the medical context, the administration of medical treatment which involves any touching, without the consent of the patient, will *prima facie* be unlawful¹⁴ and may give rise to both civil liability for damages¹⁵ as well as possible criminal proceedings for assault.¹⁶ Since the unlawfulness stems from the fact of touching itself,¹⁷ the contact need not be harmful to the patient

every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.' For a general discussion of the principles of self-determination, autonomy and inviolability, see the Law Reform Commission of Canada, Study Paper, *Consent to Medical Care* (1979) chapter 1.

¹¹ See Law Reform Commission of Canada, *Consent to Medical Care*, 3.

¹² See *Collins v Wilcock* [1984] 3 All E.R. 374, 378 where it is stated that 'The fundamental principle, plain and incontestable, is that every person's body is inviolate. It has long been established that any touching of another person, however slight may amount to a battery' (per Goff L.J.). See also the House of Lords decision in *In re F (Mental Patient: Sterilisation)* [1989] 2 W.L.R. 1025, 1066-1067, 1082-1083 and the Court of Appeal in *Re T* Court of Appeal Transcript, July 30 1992, per Lord Donaldson. These principles have been accepted in Australia; see, for example, the judgments of Nicholson C.J. of the Family Court in the cases of *In re Jane* [1989] F.L.C. 92-007, 77,243; *In re Marion* [1991] F.L.C. 92-193, 72,299-78,300.

¹³ It is now well established that there is no requirement that the touching was done with hostility. In *R v Phillips* (1971) 45 A.L.J.R. 467, 472, Barwick C.J. of the High Court had suggested that there was a requirement of hostility in order to establish battery at common law; see also Windeyer J., 479). However, in the later case of *Boughey v R* (1986) 65 A.L.R. 609 the High Court rejected a submission made in reliance upon *R v Phillips* (1971) 45 A.L.J.R. 467 that the intentional application of force to the person of an unwilling victim could not constitute battery at common law or assault or unlawful assault under the Code unless it were accompanied or motivated by positive hostility on the part of the assailant towards the victim. For discussion, see D. Lanham, 'The Right to Choose to Die with Dignity' (1990) 14 *Crim.L.J.* 401, 402-404.

In the United Kingdom, it was suggested in *Wilson v Pringle* [1987] 1 Q.B. 237, 248 per Croom Johnson L.J. that hostility is an element of the tort of battery, but this has been rejected in subsequent cases; see *T v T and another* [1988] 1 All E.R. 613, 622-625; *In re F. (Mental Patient: Sterilisation)* [1989] 2 W.L.R. 1025, 1083. Note also *Faulkner v Talbot* [1981] 1 W.L.R. 1528, 1534 dealing with the offence of battery for the purposes of the criminal law.

¹⁴ There are some exceptions, discussed below, 40-45.

¹⁵ Civil liability may arise for the torts of assault and battery. As explained in *Collins v Wilcock* [1984] 3 All E.R. 374, 377-378, both assault and battery are forms of trespass to the person. An assault is an act which causes another person to apprehend the infliction of immediate, unlawful force on his person. A battery is the actual infliction of immediate, unlawful force on another person.

For an example of a case where a patient successfully sued a doctor for damages in respect of unauthorised medical treatment see *Malette v Shulman* (1991) 2 Med.L.R. 162. On appeal, the Supreme Court of Ontario upheld the trial judge's findings that a doctor was liable for administering emergency blood transfusions to an unconscious card-carrying Jehovah's Witness. It was held that the transfusion was given in contradiction of the patient's expressed wishes and amounted to a battery. The patient was awarded damages of Can \$20,000. There have also been a number of cases in the United States where the courts have recognised that doctors may be sued for imposing life-sustaining treatment against the wishes of the patient; see *Leach v Shapiro* 13 Ohio App. 3d 393 (1984); *Bartling v Superior Court* 147 Cal. App. 3d 1006 (1983).

¹⁶ For the position in Australian common law jurisdictions (although dealt with under statutory law) see the *Criminal Law Consolidation Act* 1935 (S.A.) s. 39; *Crimes (Amendment) Act* 1981 (Vic.) amending the *Crimes Act* 1958 (Vic.); *Crimes Amendment Ordinance (No. 2)* 1990 (A.C.T.) ss. 22-26; *Crimes Act* 1900 (N.S.W.) s. 61; and under the Criminal Codes; *Criminal Code* 1983 (N.T.) s. 187-189; *Criminal Code* 1899 (Qld.) s. 245, 246, 335; *Criminal Code* 1924 (Tas.) ss. 182-184; *Criminal Code* 1913 (W.A.) s. 313, 317, 318. (Note also ss. 265-268 of the Canadian *Criminal Code* 1985; s. 192-193 of the New Zealand *Crimes Act* 1961.) On the basis of common usage, the term 'assault' is taken to cover both assault in the strict sense of the term and a battery; L. Waller and C.R. Williams, *Brett, Waller and Williams Criminal Law* (6th ed., 1989) 45.

Since criminal liability for assault is virtually never alleged against a doctor, attention will primarily be focussed on the doctor's potential civil liability for the purposes of the following discussion.

¹⁷ The term 'battery' has traditionally had connotations of harmful and offensive conduct, but as Kennedy and Grubb explain (I. Kennedy and A. Grubb, *Medical Law* (1989) 173), the essence of the 'harmfulness' and 'offensiveness' lies in the unwanted nature of the touching.

in order to give rise to liability.¹⁸ It is therefore no defence that the treatment or procedure was skilfully performed or that it was medically necessary and actually benefited the patient.¹⁹ In order to establish a valid cause of action and subject to the exceptions dealt with below,²⁰ all that needs to be shown is that the treatment was administered in the absence of consent. Where, however, the patient has consented to the particular intervention (and provided it is a medical procedure to which the patient can give a legally valid consent) the patient's consent is a complete defence to any action for damages based on the tort of battery and to any criminal proceedings.²¹

The classic exposition of these principles is to be found in the frequently cited judgment of Cardozo J. in the American case of *Schloendorff v Society of New York Hospital*:²²

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.²³

The High Court of Australia, in an appeal from the Family Court concerning the sterilisation of a handicapped minor, has endorsed the fundamental right to personal inviolability reflected in this judgment.²⁴ In the words of McHugh J.:

It is the central thesis of the common law doctrine of trespass to the person that the voluntary choices and decisions of an adult person of sound mind concerning what is or is not done to his or her body must be respected and accepted, irrespective of what others, including doctors, may think is in the best interests of that particular person ... the common law respects and preserves the autonomy of adult persons of sound mind with respect to their bodies. By doing so the common law accepts that a person has rights of control and self-determination in respect of his or her body which other persons must respect. Those rights can only be altered with the consent of the person concerned. Thus the legal requirement of consent to bodily interference protects the autonomy and dignity of the individual and limits the power of others to interfere with that person's body.²⁵

The patient's right of self-determination has also been acknowledged by the House of Lords in *In re F (Mental Patient: Sterilisation)*²⁶ in the following terms:

¹⁸ *Hart v Herron* (1984) Aust. Torts Reports 80-201, 67821.

¹⁹ For example, *Cull v Royal Surrey County Hospital and Butler* [1932] 1 B.M.J. 1195. If the patient has not suffered any harm from the treatment, damages are likely to be nominal only; P. Bates and J. Dewdney, (eds.) *Australian Health and Medical Law Reporter* 21,004.

²⁰ See below, 40-45.

²¹ There are some applications of force to which legally effective consent cannot be given for the purpose of the offence of battery; see *A-G's Reference (No. 6 of 1980)* [1981] 1 Q.B. 715. For discussion, see Kennedy and Grubb, 286-290 and their conclusion that this limitation based upon the 'public interest' should not hinder modern medical practice.

²² 211 N.Y. 125 (1914).

²³ *Id.* 126.

²⁴ *Secretary, Department of Health and Community Services v J.W.B. and S.M.B.* 6 May 1992 F.C. 92/010, 7, 29 (majority, comprised of Mason C.J., Dawson J. Toohey J. and Gaudron J.) 44 (Brennan J.), 91-92 (McHugh J.). (At the time of writing this decision has not yet been published.)

²⁵ *Id.* 91-92.

²⁶ [1989] 2 W.L.R. 1025.

At common law a doctor cannot lawfully operate on adult patients of sound mind or give them any other treatment involving the application of physical force however small, without their consent. If a doctor were to operate on such patients or give them other treatment without their consent, he would commit the actionable tort of trespass to the person.²⁷

One of the clearest statements yet of the common law right to refuse treatment was made in the case of *Re T*,²⁸ one of the rare English cases which has actually involved a refusal of treatment situation. The subject of this case, T, who had been brought up by her mother who was a Jehovah's Witness, was injured in a car accident when she was 34 weeks pregnant. She was admitted to hospital where the possibility of her receiving a blood transfusion was discussed. After a private conversation with her mother, T had indicated to the medical staff, both orally and in writing, that she did not wish to have a blood transfusion if one should become necessary. Following an emergency caesarian operation T's condition deteriorated and she required a blood transfusion. An emergency court hearing was initiated by T's father and her boyfriend (who were not Jehovah's Witnesses) and they sought a declaration that it would be lawful to administer a blood transfusion if, in the clinical judgment of the doctor, that was in the patient's best interests. At first instance, Justice Ward granted the declaration, holding that in the circumstances, it would not be unlawful for doctors to administer a blood transfusion if that was required in the best interests of the patient. An appeal was brought against this order. The Court of Appeal affirmed the decision of Ward J. on the grounds that the patient was not in a physical or mental condition which enabled her to reach a decision binding on the medical authorities and that even if, contrary to that view, she would otherwise have been in a position to reach such a decision, the influence of her mother was such as to vitiate the decision which she expressed. The case is particularly significant for the unequivocal support given to the right of a patient who has decision-making capacity, to refuse medical treatment. In the words of Lord Donaldson M.R., with whom Butler-Sloss and Staughton L.J.J. agreed:

An adult patient who ... suffers from no mental incapacity, has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered...

The law requires that an adult patient who is mentally and physically capable of exercising a choice must consent if medical treatment of him is to be lawful, although the consent need not be in writing and may sometimes be inferred from the patient's conduct in the context of the surrounding circumstances. Treating him without his consent or despite a refusal of consent will constitute a civil wrong of trespass to the person and may constitute a crime.

The common law doctrine of 'informed consent' has evolved from these fundamental principles and provides a firm basis for legal recognition of the right of a patient with decision-making capacity to refuse treatment.²⁹ Pursuant to this doctrine, a doctor is required to make full disclosure to a patient

²⁷ *Id.* 1066-67 per Lord Brandon.

²⁸ Court of Appeal Transcript, July 30 1992.

²⁹ See also the Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions* (1982) 16-17 where the doctrine of informed consent was described as a principle of law embodied within the patient's autonomy or right of self-determination requiring full disclosure to the patient.

of all proposed medical procedures, the material risks of those procedures, and alternative courses of action. On the basis of the information received from the doctor, the patient is then free to choose amongst the available treatment options. This right of a patient with decision-making capacity to give consent to treatment after having been fully informed as to the material risks of the proposed treatment, logically involves a corresponding right to *refuse* treatment. If a doctor administers treatment without the consent, or indeed, contrary to the express wishes of the patient, the patient's rights are violated. This reasoning has gained wide acceptance and it is now established beyond doubt that patients who have decision-making capacity have a common law right to refuse treatment.³⁰

In addition to the common law right to refuse treatment, a limited right to refuse treatment exists under the statute law of a number of Australian jurisdictions.³¹

The Requirement of Consent to Medical Treatment

Treatment without the patient's consent may arise either where consent is totally lacking (i.e. where there has been a failure to obtain the consent of the patient or where the treatment has been administered against the expressed wishes of a patient) or where the patient has given consent but the consent is legally invalid.³² For a consent to medical treatment to be legally effective, a number of conditions must be fulfilled; (1) the procedure/treatment must be one to which it is possible to give a legally effective consent,³³ (2) the person must have the legal capacity to give a valid consent,³⁴ and (3) the consent must be a *real* consent.³⁵

This latter requirement of a real consent demands further clarification. In certain limited circumstances, the apparent consent by a patient may be held not to be a real consent and consequently will not afford a defence to a doctor in an action for battery brought by an aggrieved patient. In order for consent to be real, it must be freely and voluntarily given. Consent which is procured by duress, fraud, or

³⁰ *Collins v Wilcock* [1984] 3 All E.R. 374, 378; *In re F (Mental Patient: Sterilisation)* [1989] 2 W.L.R. 1025, 1066-1067, 1082-1083. For Australian authority in support, see *In re Jane* [1989] F.L.C. 92-007, 77243; *In re Marion* [1991] F.L.C. 92-193, 72,299-78,300 and the appeal from this decision to the High Court; *Secretary, Department of Health and Community Services v J.W.B. and S.M.B.* 6 May 1992 F.C. 92/010. The New South Wales case of *R v Johnston* (1903) 9 A.L.R. (C.N.) 11 (decided under the *Crimes Act* 1900 (N.S.W.)) could also be interpreted as upholding the right of a patient to determine his or her own medical treatment. For discussion, see Lanham, 406-407 and below, 81. Note also the New Zealand case of *Smith v Auckland Hospital Board* [1965] N.Z.L.R. 191, 219. The position in Canada is reflected in the case of *Marshall v Curry* [1933] 3 D.L.R. 260 and more recently in the case of *Nancy B. v Hotel-Dieu de Quebec et al* 69 C.C.C. (3d) (1992) 450, 456-457.

³¹ See Vic. *Medical Treatment Act* 1988, *Medical Treatment (Enduring Power of Attorney) Act* 1990 and the *Medical Treatment (Agents) Act* 1992; S.A. *Natural Death Act* 1983; N.T. *Natural Death Act* 1988. For consideration of these legislative development, see chapter VII, 294-311. Note also the natural death and enduring power of attorney legislation which exists in the United States and Article 19.1 of the *Civil Code of Lower Canada* as amended in 1989.

³² D. Giesen, *International Medical Malpractice Law* (1988) 253.

³³ P. Skegg, *Law, Ethics and Medicine* (Revised ed., 1988) 33-40; *A-G's Reference (No 6 of 1980)* [1981] 1 Q.B. 715.

³⁴ Skegg, 47-57.

³⁵ *Chatterton v Gerson* [1981] 1 All E.R. 257.

misrepresentation is not a real consent and clearly will not be valid in law.³⁶ Further, the patient's consent must cover the procedure/treatment to be performed. Thus, if the patient consents to a particular operation or form of treatment but the treatment or procedure performed is essentially different in nature from that to which the patient consented, the patient's consent is clearly ineffective.³⁷ Not only must the patient's consent cover the treatment or procedure to be performed, it should also cover the particular person who is to perform the treatment or procedure.³⁸ Furthermore, in order for consent to be real, the doctor must provide the patient with sufficient information so that the patient understands the general nature of the procedure or treatment he or she is to undergo and is able to give a voluntary and informed consent.³⁹ Failure of a doctor to provide such basic information may be held to vitiate the patient's consent.⁴⁰ Normally, however, once the patient is informed in broad terms of the nature of the procedure which is intended, and gives a consent thereto, that consent is treated in law as a real consent⁴¹ and will be a complete defence to any civil liability for battery. In this context, reference must also be made to the legal doctrine of 'informed consent'. The doctrine of 'informed consent' concerns the amount of information that a doctor must provide to a patient regarding the proposed treatment, including information with respect to any inherent risks and possible treatment alternatives, to enable the patient to make an informed decision whether to accept or reject that treatment. The principle of informed consent protects the patient's right to autonomy and self-determination.⁴² This doctrine originated in the United States⁴³ and has taken hold in that jurisdiction and also in Canada. Early cases⁴⁴ in the evolution of this doctrine indicated that failure by a doctor to make adequate disclosure would actually vitiate consent and render the doctor liable in damages for trespass to the person. The prevailing view in a number of jurisdictions, including the

³⁶ H. Teff, 'Consent to Medical Procedures: Paternalism, Self-Determination or Therapeutic Alliance' (1985) 101 *Law Q.R.* 432, 439; *Freeman v Home Office* [1983] 3 All E.R. 589, 593, affd. [1984] 1 All E.R. 1036.

³⁷ For example, *Cull v Royal Surrey County Hospital and Butler* [1932] 1 *B.M.J.* 1195 (the surgeon had obtained consent to curettage but performed a hysterectomy); *Devi v West Midland Regional Health Authority* (1980) 7 *Current Law* 44 (a woman who had consented to a minor operation on her womb was held not to have consented to a sterilisation operation being carried out.) For the Canadian position, see *Murray v McMurchy* [1949] 2 D.L.R. 442 (the patient had consented to a caesarean birth but the doctor tied her fallopian tubes). See also the discussion of relevant principles in *Brushett v Cowan* (1991) 2 *Med.L.R.* 271. In the American case of *Cornfeldt v Tongen* 262 N.W. 2d 684, 699 (1977), it was stated that an action in battery will lie where 'the treatment consists of a touching that is of a substantially different nature and character from that to which the patient consented.' Special considerations apply with respect to emergency situations, arising, for example, during the course of an operation, where the consent of the patient cannot be obtained and the treatment is necessary to preserve the life of the patient. See below, 40-41.

³⁸ Skegg, 76 where he cites the case of *Michael v Molesworth* [1950] 2 *B.M.J.* 171 in which the patient had consented to a particular specialist to perform the operation, but it was performed by the house surgeon.

³⁹ *Chatterton v Gerson* [1981] 1 All E.R. 257, 264-265; *Freeman v Home Office* [1984] 1 All E.R. 1036, 1044.

⁴⁰ See *Chatterton v Gerson* [1981] 1 All E.R. 257, 264-265 and discussion by K. McKinnon, 'Standards of Disclosure; When Does Consent Become Informed?' (1984) 36 *Scots L. Times* 237; *Freeman v Home Office* [1984] 1 All E.R. 1036, 1044.

⁴¹ *Chatterton v Gerson* [1981] 1 All E.R. 257, 265; *Hills v Potter* [1983] 3 All E.R. 716; *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643.

⁴² M. Kirby, 'Informed Consent: What Does it Mean?' (1983) 9 *J. Med. Ethics* 69, 70.

⁴³ *Salgo v Leland Stanford Jr. University Board of Trustees* 154 Cal. App. 2d 560, (1957). For a discussion of the evolution and development of the doctrine of informed consent in the United States see G. Robertson, 'Informed Consent to Medical Treatment' (1981) 97 *Law Q.R.* 102, 104-108.

⁴⁴ For example, *Salgo v Leland Stanford Jr. University Board of Trustees* 154 Cal. App. 2d 560 (1957); *Koehler v Cook* (1975) 65 D.L.R. (3d) 766.

United Kingdom and Australia, is that where a patient has given consent to treatment, lack of information regarding risks does not deny the reality of consent as required for an action in battery, and will therefore only give rise to liability in negligence.⁴⁵ It is not proposed here to examine the extent of a doctor's duty of disclosure⁴⁶ and whether indeed, the doctrine of informed consent, as generally understood in the United States, can be said to apply in Australia and the United Kingdom.⁴⁷ For present purposes, it is sufficient to note that an action in battery is available in Australia and the United Kingdom in cases where, as a matter of fact, there is no consent at all, or where the consent was not in law a real consent.

Having noted the existence of the common law right to refuse treatment as a fundamental manifestation of the individual's right of self-determination, it now becomes necessary to examine the extent of that right. There has been little consideration in Australia or the United Kingdom of the extent of the patient's right to refuse treatment. There have only been a few cases on the subject and the issue has largely been neglected in the academic literature.

In examining the extent of the patient's right to refuse treatment, attention will initially be focussed on the circumstances in which medical treatment or procedures can lawfully be performed *without* the consent of the patient.

⁴⁵ The position in the United Kingdom is reflected in the cases of *Chatterton v Gerson* [1981] 1 All E.R. 257, 265; *Hills v Potter* [1983] 3 All E.R. 716; *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643. For authorities on the Australian position see *Hart v Herron* [1984] Aust. Torts Reports 80-201, 67,823 ('the appropriate place for informed consent is in the context of a count in negligence based upon alleged failures to warn or inform' per Fisher J.) and a number of South Australian cases involving inadequate disclosure in which proceedings have been brought in negligence; *F v R* [1984] 33 S.A.S.R. 189; *Battersby v Tottman* (1985) 37 S.A.S.R. 542; *Gover v S.A.* (1985) 39 S.A.S.R. 543; *Petrunic & Anor v Barnes* [1988] Aust. Torts Reports 80-147. This approach has recently been confirmed by the High Court; *Rogers v Whitaker* 19 Nov. 1992, 92/045, 11.

For the position in the United States see, for example, *Natanson v Cline* 186 Kan. 393 (1960); *Canterbury v Spence* 464 F. 2d 772 (1972); *Cobbs v Grant* 8 Cal. 3d 229 (1972). For the Canadian position see *Reibl v Hughes* (1980) 114 D.L.R. (3d) 1. Although the courts in the United States and Canada have moved away from actions based on trespass in favour of negligence actions, the concept of 'informed consent' has been retained to impose upon doctors an obligation to provide the patient with information about the treatment which is proposed.

There are a number of policy reasons behind limiting liability of doctors for battery and holding that cases involving inadequate disclosure (as distinct from the complete failure to obtain consent) should be brought in negligence; see Robertson, 123-4; A. Grubb, 'The Emergence and Rise of Medical Law and Ethics' (1987) 50 *Mod.L.Rev.* 241, 249-250. Some commentators have, however, been critical of this approach and have argued that it would be more realistic to frame the action in trespass rather than negligence since there cannot be *real* consent in the absence of full information; e.g. B. Bromberger, 'Patient Participation in Medical Decision-Making: Are the Courts the Answer?' (1983) 6 *U.N.S.W.L.J.* 1, 17; M. Gochnauer and D.J. Fleming, 'Tort Law - Informed Consent - New Directions for Medical Disclosure - *Hopp v Lepp* and *Reibl v Hughes*' (1981) 15 *U.B.C.L.Rev.* 475, 488; M. Somerville, 'Structuring the Issues in Informed Consent' (1981) 26 *McGill L.J.* 740, 742-752. See also Teff, 438-440 for an outline of the advantages of an action based upon trespass as distinct from negligence.

⁴⁶ The most authoritative Australian statement regarding the scope of a doctor's duty of disclosure to a patient can be found in *Rogers v Whitaker* 19 Nov. 1992, 92/045. For discussion of the standard of doctors' duty of disclosure developed in Australia (based on the earlier South Australian authorities which have been upheld by the High Court) as compared with United Kingdom and the United States see M. Wood, 'Informed Consent - The Australian Position' (1990) 20 *Qld.L.S.J.* 121.

⁴⁷ The High Court in *Rogers v Whitaker* 19 Nov. 1992, 92/045, 10-11 was wary of the use of the phrase 'informed consent' but strongly endorsed the view that doctors must give patients warning about 'material risks'. Doubt remains in the wake of the *Sidaway Case* [1985] 1 All E.R. 643 as to the status of the informed consent doctrine in the United Kingdom. Compare for example, the views of Teff, 434 and P. Gerber, 'Informed Consent - the Last of Mrs Sidaway?' (1985) 142 *M.J.A.* 643 with that of Kennedy, *Treat Me Right*, 193-212.

Justification for Medical Treatment Performed Without the Patient's Consent

The principal situation where the consent of the patient to medical treatment is not required is in cases of emergency where the treatment provided was necessary to save the life or *seem*, to preserve the health of the patient. Circumstances may arise where a patient is in immediate need of treatment, but because of his or her condition, is unable to give consent to treatment. Although there is little authority directly on the point in either England or Australia,⁴⁸ it would appear that in such cases, the law would allow the defence of necessity in respect of any action brought by an aggrieved patient.⁴⁹ The basis of the defence of necessity is that acting unlawfully (in this case, providing treatment without the patient's consent), is justified if the resulting good effect materially outweighs the consequences of adhering strictly to the law.⁵⁰ In order to succeed with such a defence, it is likely that the doctor would have to show that the treatment which was administered was necessary in order to save the life or preserve the health of the patient⁵¹ and that it would have been unreasonable to postpone intervention until consent could be obtained.⁵² Furthermore, the treatment which is provided should not go beyond what is necessary to cope with the particular emergency. Another important limitation is that the defence is only available in circumstances where the patient is not known to object to the treatment in question.⁵³ The fact that treatment is necessary to save the life or preserve the health of the patient does not justify the imposition of treatment against the patient's

⁴⁸ See dicta in *T v T and another* [1988] 1 All E.R. 613, 621; *In re F (Mental Patient: Sterilisation)* [1989] 2 W.L.R. 1025, 1036, 1057, 1084; cited with approval by Nicholson C.J. in *In re Marion* [1991] F.L.C. 92-193, 78,299. Note also the judgment of McHugh J. of the High Court in *Secretary, Department of Health and Community Services v J.W.B. and S.M.B.* 6 May 1992 F.C. 92/010, 92-93. In the United States and Canada, the defence of necessity has been recognised by the courts; see *Pratt v Davies* 224 Ill. 300, 309 (1906) and the Canadian case *Marshall v Curry* [1933] 3 D.L.R. 260. The recent English Court of Appeal decision in *Re T* (Court of Appeal Transcript, July 30 1992) has confirmed that in an emergency situation, where the patient has made no choice and is in no position to make one, the practitioner can lawfully treat the patient in accordance with his or her clinical judgment of what is in the patient's best interests.

⁴⁹ A number of commentators have indicated their support for the existence of such a defence: e.g. D. Kloss, 'Consent to Medical Treatment' (1965) 5 *Med.Sci. Law* 89, 90-91; G. Williams, 'The Defence of Necessity' (1953) 6 *C.L.P.* 216; Geisen, 323; P. Skegg, 'A Justification for Medical Procedures Performed Without Consent' (1974) 90 *Law Q.Rev.* 512, 512-514. The defence of necessity is potentially applicable to both criminal and civil liability that a doctor may incur as a result of unauthorised treatment. The alternative suggestion made in *Wilson v Pringle* [1987] Q.B. 237 that operative treatments (and presumably other forms of medical treatment) are justifiable on the grounds that they come within the ordinary conduct of everyday life, (per Croom-Johnson L.J.) has been rejected in subsequent cases; see Wood J. in *T v T and another* [1988] 1 All E.R. 613; Butler-Sloss L.J. in *In re F (Mental Patient: Sterilisation)* [1989] 2 W.L.R. 1025,1057.

⁵⁰ J.K. Mason and R.A. McCall Smith, *Law and Medical Ethics* (2nd ed., 1987) 143.

⁵¹ This is the approach which has been adopted by the Canadian courts; e.g. *Marshall v Curry* [1933] 3 D.L.R. 260; *Mulloy v Hop Sang* [1935] 1 W.W.R. 714. However, there is, as yet, no uniformly accepted understanding of what constitutes an emergency; i.e. whether it must be threatening to the patient's life or whether it is sufficient that there is a risk of grave physical and/or mental injury. See also L. Skene, *You, Your Doctor and the Law* (1990) 38.

⁵² See also Skegg, 'A Justification for Medical Procedures Performed Without Consent,' 517-519 where a distinction is drawn between treatment merely being convenient on the one hand, which clearly does not justify intervention, and circumstances where it would be *unreasonable* to postpone intervention until consent could be sought. Compare *Marshall v Curry* [1933] 3 D.L.R. 260 and *Murray v McMurchy* [1949] 2 D.L.R. 442.

⁵³ See *Mulloy v Hop Sang* [1935] 1 W.W.R. 714. See also *Malette v Shulman* (1991) 2 Med.L.R. 162 in which the Supreme Court of Ontario ruled that the doctor had no authorisation under the emergency doctrine to override the patient's wishes. It should be noted that different considerations may apply in relation to the treatment of attempted suicides. See chapter III, 108-109.

expressed wishes. Allowing the defence of necessity in these limited circumstances gives effect to the value of saving life, without detracting from the patient's right of self-determination.

In some jurisdictions relevant statutory provisions exist which may empower a doctor or other health care professional to provide emergency treatment in specified circumstances.⁵⁴

Scope of a Patient's Right to Refuse Treatment at Common Law

Although there is little authority dealing directly with the scope of a patient's right to refuse treatment at common law, the overwhelming view is that a patient who has decision-making capacity has a right of self-determination and may refuse even life-saving treatment.⁵⁵ A significant contribution has been made to this subject by the Court of Appeal in the recent English decision of *Re T*⁵⁶ referred to earlier.⁵⁷ Although upholding the decision of the court below for the administration of treatment against the apparent wishes of the patient, the Court of Appeal strongly defended the *prima facie* right

⁵⁴ For example, N.S.W. *Ambulance Services Act* 1900 s. 26; Qld. *Medical Act* 1939 s. 52, *Voluntary Aid in Emergencies Act* 1973 s. 3; S.A. *Medical Practitioners Act* 1983 s. 37a, *Consent to Medical and Dental Procedures Act* 1985 s. 7; Tas. *Criminal Code* 1924 s. 51(3). (Note also the *Criminal Code* 1899 (Qld.) s. 282; *Criminal Code* 1913 (W.A.) s. 259.) See also s. 62 of the *Mental Health Act* 1983 (U.K.) dealing with urgent treatment which Kennedy and Grubb, 298 describe as a statutory example of the doctrine of necessity.

⁵⁵ Judicial support for this proposition can be found in the judgments in *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643 (see, in particular, Lord Scarman, (in dissent) 649) and in the judgment of Nicholson C.J. in *In re Marion* [1991] F.L.C. 92-193, 78,299. Many commentators can be cited in support of this view; e.g. G. Williams, 'The Right to Die' (1984) 134 *New L.J.* 73; Skegg, 'A Justification for Medical Procedures Without Consent' 523-529; Kennedy, *Treat Me Right*, 320; Kennedy and Grubb, 346; Geisen, 258-260, 456-464. Influential support for this view can also be found in the writings of P. Devlin, *Samples of Law Making* (1962) 93.

More difficult questions arise regarding patients who have lost decision-making capacity but who have previously indicated their wishes with regard to treatment in a living will or other form of advance directive in jurisdictions where there is no legislation giving legal effect to such documents. (The only jurisdictions in Australia to make provision for a living will are South Australia and the Northern Territory; see discussion below in chapter VII, 294-297 and 310-311 respectively.) Some Australian commentators have emphasised the uncertainty of the present state of the law; see, for example, the opinion of Mr Ron Castan Q.C. sought for the Parliament of Victoria Social Development Committee Inquiry and discussed in the Parliamentary debates with regard to the Victorian *Medical Treatment Bill* Vic. Parl. Deb. (L.C.), Vol. 391, 23 March (1988) 1013-1014. See also D. Lanham and B. Fehlberg, 'Living Wills and the Right to Die with Dignity' (1991) 18 *Melbourne U.L.Rev.* 329, 331-332. There is no case law in Australia directly dealing with this issue. However, in the recent English case of *Re T* (Court of Appeal Transcript, July 30 1992) the Court of Appeal approved the decision of the Ontario Court of Appeal in *Malette v Shulman* (1991) 2 Med.L.R. 162 where a Jehovah's Witness successfully sued the medical authorities for damages for administering a blood transfusion, contrary to the expressly stated wishes on a card carried by the patient. The English Court of Appeal went on to give some guidance as to the circumstances in which an advance directive would be legally binding on the medical authorities. Essentially, the court held that a directive made by a patient who has decision-making capacity will be valid if the patient has anticipated and intended his decision to apply in circumstances that ultimately prevail. For discussion of this aspect of the court's decision, see A. Grubb 'Refusal of Medical Treatment: I - The Competent Adult' (1992) Vol. 3 No. 1 *Dispatches* 1. On the basis of this decision in *Re T* and the earlier Canadian case of *Malette v Shulman* (1991) 2 Med.L.R. 162 as well as the United States authorities discussed below, (see in particular, *In re Conroy* 486 A. 2d 1209, 1229-1230 (1985); *Cruzan v Director, Missouri Department of Health* 111 L. Ed. 2d 224 (1990)) it can be argued that an advance directive in which the patient's wish to refuse particular treatment is clearly stated, should have the same force as the refusal of treatment by a patient who has decision-making capacity. The only relevant difference would be of an evidentiary nature in terms of ascertaining whether the directive reflects the patient's wishes, whether that constituted a continuing wish etc.

⁵⁶ Court of Appeal Transcript, July 30 1992.

⁵⁷ See above, 36.

and capacity of every adult to decide whether or not he or she will accept medical treatment, even if a refusal may risk permanent injury to his or her health or lead to premature death. Moreover, as the Court of Appeal made clear, the exercise of this right to refuse treatment does not depend on the objective reasonableness of the patient's decision or whether the treating doctor(s) approve of the course chosen by the patient. Provided the patient has decision-making capacity, the right to refuse treatment is paramount, no matter how unreasonable or foolish that refusal may seem to the patient's medical advisers⁵⁸ or even if the reasons for that refusal are unknown or non-existent.⁵⁹

The right to refuse medical treatment recognised by the court in *Re T* is potentially far-reaching. It extends not only to patients who are terminally ill, but to patients whose lives are salvageable and yet who refuse life-saving treatment.⁶⁰ Although extensive, the patient's right to refuse treatment is not absolute and as noted by the Court of Appeal in *Re T*, there are a number of limitations on the exercise of this right.

Requirement of Decision-Making Capacity

A major qualification on the patient's right to decline medical treatment is the requirement that the patient exercising that right must have decision-making capacity.⁶¹ The mental capacity of the patient is therefore critical in determining the validity of a patient's refusal of treatment. The law presumes a person to be competent and have decision-making capacity unless proven otherwise.⁶² The notion of competency requires that the patient has the capacity or ability to understand, to a reasonable extent, the nature and consequence of his or her decision, including the risks and benefits of and the alternatives to a specific treatment.⁶³ In practice, the seemingly fundamental right of self-determination can readily be undermined by a finding that the patient lacks the necessary decision-making capacity to exercise that right.⁶⁴ The major difficulty appears to be that the request by a patient that life-sustaining treatment be withheld or withdrawn may readily be interpreted as an indication of unsoundness of mind, since it is generally presumed that no-one really wants to die.⁶⁵ Thus, a patient who expresses a wish to die and directs that life-saving treatment be withheld or discontinued is at risk of being found to lack the necessary decision-making capacity, and therefore as

⁵⁸ See also McHugh J. of the High Court in *Secretary, Department of Health and Community Services v J.W.B. and S.M.B.* 6 May 1992 F.C. 92/010, 91-92; *Smith v Auckland Hospital Board* [1965] N.Z.L.R. 191, 219 per Grasson J.; *Lane v Candura* 376 N.E. 2d 1232 (1978). In practice, however, the objective reasonableness of the patient's decision may affect the assessment of the patient's decision-making capacity. See discussion below, 42-43.

⁵⁹ Court of Appeal Transcript, July 30 1992 per Lord Donaldson M.R.

⁶⁰ Grubb, 'Refusal of Medical Treatment: I - The Competent Adult,' 2.

⁶¹ For a discussion of the meaning of 'decision-making capacity', see the Introduction to this thesis, 6-7.

⁶² See also *Re T* referred to above, 36, 41-42.

⁶³ On the facts of *Re T* Lord Donaldson M.R. held that T's physical and mental condition was such that she had lacked the capacity to refuse treatment.

⁶⁴ I. Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors' (1976) *Crim.L.Rev.* 217, 222; B. Dickens, 'The Right to a Natural Death' (1981) 26 *McGill L.J.* 847, 849-851.

⁶⁵ Kennedy, 'The Legal Effects of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors,' 222; Kennedy and Grubb, 346 where the authors suggest that there is a tendency in the courts to avoid attacking the principle of inviolability of the person head on and instead, to cast doubt on the competence of the person whose decision is in question.

being unable to effectively withhold or withdraw his or her consent.⁶⁶ The difficulties are compounded by the fact that it is the doctor's responsibility to make a determination about the patient's decision-making capacity.⁶⁷ A doctor who disapproves of a patient's decision to reject treatment can, through a finding of incapacity, justify the medical interventions that the doctor favours. Another factor which militates against the patient is that the professional training of doctors predisposes them to saving lives and treating the sick and they may consequently be disinclined to respond to the request of a patient that treatment be discontinued.⁶⁸

It is a matter of real concern that the question of a patient's decision-making capacity, which is the linchpin for the exercise of patient autonomy, should be so susceptible to defeat. The fact that a patient's decision to refuse treatment may appear unreasonable should not of itself justify the conclusion that the patient is incompetent in the legal sense.⁶⁹ Moreover, if the 'right to refuse treatment' is to have any substance, appropriate procedures must be in place for the independent assessment of patient decision-making capacity in accordance with clear standards and a structured and reviewable process.⁷⁰

Consent Vitiating by Undue Influence

Another exception which was in issue in the case of *Re T*, arises in circumstances where the patient's capacity to make a decision has been overborne by the will of others. As noted earlier,⁷¹ the Court of Appeal in that case held that apart from the question of T's condition and the effect that that would have on her decision-making capacity, T's refusal was invalid because it was vitiated by the pressure exerted by her mother at the hospital which amounted to undue influence.⁷² Whilst recognising that a patient is entitled to seek advice from others in reaching a decision, particularly from family members, the court stated that doctors have to consider whether the decision is really that of the patient. The real question in each case is: does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is

⁶⁶ B. Naylor, 'Death with Dignity Legislation in Victoria' (1987) 12 *L.S.B.* 273. The much publicised John McEwan case in Victoria acutely highlighted the problems which can arise in this area. John McEwan, former Australian water-skiing champion, became a quadriplegic as the result of an accident. After expressing a wish to die and refusing further treatment, he was certified insane. For coverage of this case, see the Victorian Social Development Committee Report, Appendix I and N. Tonti-Fillippini, 'Some Refusals of Medical Treatment Which Have Changed the Law in Victoria' (1992) 157 *M.J.A.* 277, 277-278.

⁶⁷ Kennedy, 'The Legal Effects of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors,' 222.

⁶⁸ *Ibid.*

⁶⁹ For example, the case of *Lane v Candura* 376 N.E. 2d 1232 (1978) in which the court distinguished the question of patient competence from that of medical reasonableness and held that the irrationality of the patient's decision did not justify the conclusion that she was incompetent in the legal sense.

⁷⁰ G.P. Smith, 'All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?' (1989) 22 *U.Calif., Davis* 275, 381; Hastings Center Report *Guidelines on the Termination of Life-Sustaining Treatment and Care for the Dying* (1987) 23, 131; G. Annas and L. Glantz, 'The Right of Elderly Patients to Refuse Life-Sustaining Treatment' (1986) 64 *Milbank Q.* 95, 112-113. See also Kennedy, *Treat Me Right*, 321 where he suggests that the most appropriate mechanism for safeguarding both the patients' and the doctors' interests is for the hospital to document the circumstances fully in the notes and have the patient's competence assessed by a qualified person not otherwise concerned in the patient's case.

⁷¹ See above, 36.

⁷² For analysis of this aspect of the court's decision, see Grubb, 'Refusal of Medical Treatment: I - The Competent Adult,' 3.

such that he can no longer think and decide for himself? When assessing the extent of external influences, doctors should have particular regard to the strength of the will of the patient (e.g. whether the patient was tired, in pain or depressed) and the relationship between the patient and the persuader (whether, for example, the persuader was in a position of power over the patient.) In *Re T* the court held that in circumstances where the patient's capacity to make a decision has been overborne by others it is the duty of the doctors to treat him or her in whatever way they consider, in the exercise of their clinical judgment, to be in his or her best interests.

Protection of a Viable Fetus

Another possible exception to the right of an adult patient with decision-making capacity to refuse medical treatment which was noted by Lord Donaldson M.R. in *Re T* is the situation where the patient's decision may lead to the death of a viable fetus.⁷³ This was noted by his Lordship to be a novel problem of considerable legal and ethical complexity, but on the facts of *Re T* the issue did not directly arise. Despite the tentative nature of this possible suggestion, it has already been relied upon in a subsequent case to override a pregnant woman's refusal of treatment.⁷⁴ In the recent case of *Re S*, Sir Stephen Brown of the High Court, exercising the court's inherent jurisdiction, granted a declaration authorising the surgeon and staff to carry out an emergency caesarian operation notwithstanding the patient's religious objection, on the grounds that it was in the best interests of the defendant and necessary to save the life of the unborn child. This decision is open to criticism on that basis that it undermines the autonomy and right of self-determination of female patients who are carrying a viable fetus, and is inconsistent with earlier English authority regarding the status of an unborn child.⁷⁵ In the absence of an authoritative ruling on the matter by a higher court, the position in the United Kingdom remains uncertain but, in rejecting this decision, commentators have vigorously defended the right of a woman to refuse treatment even if that refusal leads to the death of the baby.⁷⁶ In view of the uncertainty surrounding this case and for reasons of principle, this does not appear to be a desirable precedent for the Australian courts to follow.

Statutory Exceptions to the Patient's Right to Refuse Treatment

A clear exception to the patient's common law right to refuse treatment is public health legislation which contain provisions regarding compulsory treatment in certain circumstances.⁷⁷ This legislation is concerned with the control of infectious diseases and allows for the involuntary detention and/or treatment of individuals who are presenting a threat to the public. The primary focus of the legislation is to protect the interests of the public rather than the interests of any particular person who may be ill.⁷⁸ Statutory exceptions to the common law right to refuse medical treatment and other

⁷³ Court of Appeal Transcript, July 30 1992.

⁷⁴ *Re S* High Court Transcript, October 13 1992.

⁷⁵ See D. Morgan, 'Whatever Happened to Consent?' (1992) 142 *New L.J.* 1448; Grubb, 'Refusal of Medical Treatment: I - The Competent Adult,' 2 (referring to *Re F (in utero)* [1988] Fam. 122).

⁷⁶ *Ibid.*

⁷⁷ For example, N.S.W. *Public Health Act* 1991 ss. 21-42; S.A. *Public and Environmental Health Act* 1987 ss. 31-34; Vic. *Health Act* 1958 ss. 120-122; and in the United Kingdom, the *Public Health (Control of Diseases) Act* 1984.

⁷⁸ Kennedy and Grubb, 365.

interventions are also contained in other legislation⁷⁹ including the mental health legislation,⁸⁰ prison legislation⁸¹ and traffic or road safety legislation governing the compulsory testing of bodily fluids.⁸²

Suicide Prevention

Another qualification upon the patient's common law right to refuse treatment arises in cases of suicide, where a doctor may be justified in taking action to save the patient's life in the absence of consent and possibly against the wishes of the patient. Although in some cases, a person who has attempted to commit suicide will be suffering from a mental disorder which deprives the patient of decision-making capacity, in many cases, the person will have sufficient understanding to give or withhold consent.⁸³ A doctor may, nevertheless, be justified in intervening, and may even be under a duty to do so in circumstances where there is reason to believe that if given help, the person will be glad that he or she did not kill or seriously injure him or herself.⁸⁴ Whilst there is little direct authority on the matter, the legal basis for this exception would most readily come within the category of necessity, considered above in the context of emergency cases.⁸⁵ The area of suicide and the rights and duties of doctors treating suicidal patients is the subject of more detailed consideration in the following chapter.⁸⁶

The Position in the United States

The legal position in the United States with regard to the patient's right to refuse treatment deserves special consideration. The patient's right to refuse treatment has been most frequently litigated in that country and there is now a considerable body of case law dealing with the subject. The courts in the United States have addressed many of the issues in this area: the circumstances in which a patient's

⁷⁹ For reference to legislation permitting doctors or other health care professionals to provide emergency treatment, see above, n. 54.

⁸⁰ A.C.T. *Mental Health Act* 1983 s. 21; N.S.W. *Mental Health Act* 1990 s. 10 Ch. 4 Pt. 2; N.T. *Mental Health Act* 1979 ss. 9-10; Qld. *Mental Health Services Act* 1974 ss. 25-26; S.A. *Mental Health Act* 1977 s. 18; Tas. *Mental Health Act* 1963 ss. 99-100; Vic. *Mental Health Act* 1986 ss. 10-11; W.A. *Mental Health Act* 1962 s. 29, 31. See Bates and Dewdney, para 20-170 - 20-250 for analysis. See also the *Mental Health Act* 1983 (U.K.) s. 63 and the discussion in Kennedy and Grubb, 364-365. As those authors point out, not all persons who are liable to be detained and are subject to compulsory detention are by that reason alone incompetent in a legal sense. The legislation therefore clearly envisages the administration of medical treatment against the refusal of even a competent patient. For reference to mental health legislation in other jurisdictions under consideration, see Giesen, 452.

⁸¹ For example, s. 16 of the *Prisons Act* 1952 (N.S.W.) which provides for compulsory medical treatment where the life or health of a prisoner is likely to be endangered or seriously prejudiced by the failure of such prisoner to undergo medical treatment.

⁸² In most Australian jurisdictions, traffic or road safety legislation provides for the taking of blood samples in certain circumstances without the person's consent. For an outline of the legislation, see Bates and Dewdney, para. 37-000-37-090. In some States, legislation also exists providing for the compulsory detention and treatment of certain alcoholic and drug dependent people; see, for example, Tas. *Alcohol and Drug Dependency Act* 1968; Vic. *Alcoholics and Drug-Dependent Persons Act* 1968.

⁸³ Skegg, *Law Ethics and Medicine*, 111.

⁸⁴ *Id.* 112. A doctor may be liable in negligence for breach of a civil duty to protect a suicidal patient from foreseeable harm, (e.g. *Selfe v King George Hospital*, (unreported) *The Times* 26 Nov. 1970) and may even be liable under criminal law principles for manslaughter on the grounds of criminal negligence.

⁸⁵ See above, 40-41.

⁸⁶ Chapter III, 107-110.

refusal of treatment will be upheld; what kinds of treatment a patient has a legal right to refuse; and what qualifications a State may seek to impose on the exercise of a patient's right to refuse treatment. The case law in the United States may well be influential in the future in shaping Australian and English law in this area, particularly in light of the dearth of case law in these jurisdictions.

The courts in the United States have generally recognised the right of a patient to refuse life-prolonging and even life-saving medical treatment.⁸⁷ There has, however, been considerable uncertainty as to the proper basis of this right: whether it has a constitutional basis or whether it is based on the right to bodily integrity recognised at common law.⁸⁸ In the case of *In re Quinlan*,⁸⁹ the Supreme Court of New Jersey presumed that the constitutional right of privacy established in *Griswold v Connecticut*⁹⁰ was broad enough to encompass a patient's decision to decline medical treatment. On the basis of this assumption, courts in various other American States have followed *In re Quinlan* and have relied upon the constitutional right of privacy in support of the right of a patient to decline treatment.⁹¹ The constitutional right of privacy is in many respects similar to its common-law counterpart. Both are founded on principles of autonomy and self-determination⁹² and in their treatment by the courts, the two have become somewhat merged and almost indistinguishable.⁹³ In some cases, the courts in the United States have based their recognition of the right to refuse

⁸⁷ The court system in the United States is organised along federal lines; there is a court hierarchy in each of the State jurisdictions, culminating in the State Supreme Courts and there is a Federal Supreme Court which deals predominantly with federal matters. There have been numerous decisions at the State level upholding the patient's right to refuse treatment; e.g. *Erickson v Dilgard* 252 N.Y.S. 2d 705 (1962); *In re Brooks' Estate* 32 Ill. 2d 361 (1965); *In re Quinlan* 355 A. 2d 647 (1976); *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986); *In re Farrel* 529 A. 2d 404 (1987). The case of *Cruzan v Director, Missouri Department of Health* 111 L. Ed. 2d 224 (1990) (hereafter referred to as the *Cruzan* case), was the first time that the United States Supreme Court acknowledged the existence of this right.

⁸⁸ Compare, for example, *In re Quinlan* 355 A. 2d 647 (1976) and *Bartling v Superior Court* 163 Cal. App. 3d 186 (1984) which rely upon the constitutional right of privacy with *In re Storar* 52 N.Y. 2d 363 (1981); *In re Eichner* 52 N.Y. 2d 363 (1981) and *In re Conroy* 486 A. 2d 1209 (1985) which rely on the common law. The Supreme Court has previously noted that the constitutional privacy right includes the freedom to care for one's health and person (*Doe v Bolton* 410 U.S. 179 (1973)) but, until the *Cruzan* case, the court had not considered whether that freedom includes the right to refuse life-saving medical treatment.

⁸⁹ 355 A. 2d 647 (1976) (The facts of the case are set out below, 52.)

⁹⁰ 381 U.S. 479 (1965) in which the United States Supreme Court found that although the United States Constitution does not specifically mention a right to privacy, a right to privacy exists in the penumbra of specified guarantees in the Bill of Rights. The right of privacy was subsequently extended in *Roe v Wade* 410 U.S. 113 (1973) and was held to include the decision of a woman to have an abortion.

⁹¹ For example, *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417 (1977); *Severns v Wilmington Medical Center* 421 A. 2d 1334 (1980); *In re Colyer* 99 Wash. 2d 114 (1983); *Bartling v Superior Court* 163 Cal. App. 3d 186 (1984).

A privacy right founded on the United States Constitution and applied to the States through the Fourteenth Amendment only extends to situations involving State action. (*United States v Stanley* 109 U.S. 3, 11-12 (1883)) The courts have, however, recognised a sufficient nexus between the State and the challenged action so as to imply State presence, for example, in the State's capacity to impose criminal sanctions (*In re Colyer* 99 Wash. 2d 114, 121 (1983)) and a State's licensing of physicians (*Rasmussen v Fleming* 154 Ariz. 207, 215, n. 9 (1987)). Some commentators have been critical of the attempt to extend the constitutional right of privacy to protect a patient's right to refuse medical treatment; e.g. E. Lyon, 'The Right to Die: An Exercise of Informed Consent, Not an Extension of the Constitutional Right to Privacy' (1990) 58 *U.Cin.L.Rev.* 1367.

⁹² See *In re Conroy* 486 A. 2d 1209, 1222-23 (1985); N. Cantor, *Legal Frontiers of Death and Dying* (1987) 9.

⁹³ A. Clarke 'The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical - Ethical Consensus' (1979-80) 13 *Creighton L.Rev.* 795; N. Cantor, 'Conroy, Best Interest, and the Handling of Dying Patients' (1985) 37 *Rutgers L.Rev.* 543, 547.

treatment on both the constitutional and common law grounds.⁹⁴ However, in the absence of a definitive ruling on the issue from the United States Supreme Court and with indications that the Supreme Court was narrowing its conception of privacy,⁹⁵ some State courts deliberately refrained from basing the right to refuse treatment upon the constitutional right of privacy. As a result, there has been increasing reliance upon the more widely accepted common law prerogative to refuse treatment.⁹⁶ Since the right to refuse treatment at common law and under the Constitution are virtually indistinguishable, it makes little difference to the *content* of that right which of the two sources is relied upon.⁹⁷ One advantage of basing the right on the Constitution would be to ensure that it could not subsequently be altered by the legislature.⁹⁸ However, some commentators are of the view that the right to refuse treatment in the United States does not need constitutional support,⁹⁹ and that there are in fact distinct advantages in grounding the right in common law principles.¹⁰⁰

The recent case of *Cruzan v Director, Missouri Department of Health*¹⁰¹ was the first time in which the United States Supreme Court heard a case involving the right of a patient to refuse life-sustaining medical treatment and was faced with the issue whether the United States Constitution confers a right to refuse life-sustaining treatment.¹⁰² However, a majority of the Supreme Court declined to address the issue whether the right to refuse life-sustaining medical treatment is protected by a constitutional right to privacy, preferring instead to analyse it in terms of a Fourteenth Amendment liberty interest which was seen as implicit in previous court decisions.¹⁰³ The Supreme Court held that a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment.¹⁰⁴ The court 'assumed, for the purposes of this case' that the constitutionally protected liberty interest for competent persons includes the right to refuse life-saving hydration and nutrition and went on to frame

⁹⁴ For example, *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417 (1977); *Satz v Perlmutter* 362 So. 2d 160 (1978); *In re Spring* 380 Mass. 629 (1980); *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986). Some courts have also recognised a right of privacy under State Constitutions; e.g. *In re Barry* 445 So. 2d 365, 370 (1984).

⁹⁵ Cantor, *Legal Frontiers of Death and Dying* 9-10. See, for example, *Roberts v United States Jaycees* 104 S.Ct. 3244, 3250 (1984) and *Bowers v Hardwick* 478 U.S. 186, 191-95 (1986) in which the Supreme Court resisted expansion of the privacy right.

⁹⁶ *In re Storar* 52 N.Y. 2d 363 (1981); *In re Eichner* 52 N.Y. 2d 363 (1981); *Barber v Superior Court* 195 Cal. Rptr. 484 (1983); *In re Conroy* 486 A. 2d 1209 (1985).

⁹⁷ Cantor, *Legal Frontiers of Death and Dying*, 10.

⁹⁸ *Ibid.* and D. Horan, 'The Quinlan Case' in D. Horan and D. Mall, (eds.) *Death, Dying and Euthanasia* (1980) 526.

⁹⁹ Horan, 527.

¹⁰⁰ As Cantor points out, (*Legal Frontiers of Death and Dying*, 10) if the right is anchored in the common law, the patient need not establish 'State action' or government involvement in order to assert his legal right. Furthermore, there may be advantages with respect to damages.

¹⁰¹ 111 L. Ed. 2d 224 (1990).

¹⁰² The facts of this case are dealt with below, 58. The trial court held that a fundamental right exists under the Missouri and United States Constitutions to refuse medical treatment. On appeal, the Missouri Supreme Court reversed the trial court's decision, and expressed doubts as to whether a constitutional privacy right was applicable; *Cruzan v Harmon* 760 S.W. 2d 408 (1988).

¹⁰³ 111 L. Ed. 2d 224, 241-242 (1990). For analysis of the courts approach, see W. Leschensky, 'Constitutional Protection of the "Refusal-of-Treatment";' *Cruzan v Director, Missouri Department of Health*, 110 S.Ct. 2841 (1990) (1991) 14 *Harv.J.L. & Pub.Pol'y.* 248, 254-255. Justice Scalia, who wrote a concurring judgment, was the only member of the court to expressly reject any constitutionally protected right or interest, based largely on his view that forgoing nutrition and hydration is indistinguishable from ordinary suicide; 111 L. Ed. 2d 224, 251-256 (1990).

¹⁰⁴ 111 L. Ed. 2d 224, 241-242 (1990). The Due Process Clause in the Fourteenth Amendment of the United States Constitution provides that 'No State shall ... deprive any person of life, liberty, or property without due process of law'.

the question before the court in very narrow terms.¹⁰⁵ The court emphasised that this was the first case in which the Supreme Court had been squarely presented with the issue of whether there is a constitutionally protected 'right to die' and referred to the court's previously stated principle of judicial restraint; that in deciding 'a question of such magnitude and importance ... it is the better part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject'.¹⁰⁶ Notwithstanding the tentative nature of the Supreme Court's finding, the case is significant for its recognition of a constitutionally protected liberty interest to refuse life-saving medical treatment.¹⁰⁷ However, the refusal by the majority of the court to recognise a fundamental privacy interest¹⁰⁸ is of some significance.¹⁰⁹ In constitutional terms, a 'fundamental right' is subject to strict scrutiny and cannot be abridged in the absence of a compelling State interest.¹¹⁰ A liberty interest, on the other hand, is a weaker interest, and subject to State regulation so long as the regulation is rationally related to the legitimate State interest.¹¹¹

It should be noted that in addition to the common law and constitutional right to refuse treatment, a majority of American States have natural death or 'living will' legislation which confers a limited statutory right to refuse medical treatment.¹¹²

The Right to Refuse Treatment and Countervailing State Interests

Whether the right to refuse treatment is grounded in the common law or the Constitution, it is not an absolute right.¹¹³ The American courts have held that the right of a patient to refuse treatment must be balanced against a number of State interests: the State's interest in (1) the protection of innocent third parties; (2) the prevention of suicide; (3) the preservation of life; and (4) the safeguarding of the ethical integrity of the medical profession.¹¹⁴ Only if the individual's right to self-determination

¹⁰⁵ 111 L. Ed. 2d 224, 241-242 (1990). The main issue for determination was whether the Federal Constitution prohibited the State of Missouri from requiring 'clear and convincing evidence' of an incompetent patient's previously expressed wishes to terminate life-sustaining medical treatment. For further discussion, see below, 59-60.

¹⁰⁶ 111 L. Ed. 2d 224, 241 (1990) referring to the court's earlier decision in *Twin City Bank v Newbaker* 167 U.S. 196, 202 (1897).

¹⁰⁷ See also G. Annas, 'The Long Dying of Nancy Cruzan' (1991) 19 *Law, Med. & Health Care* 52, 55. It has been suggested that the Canadian *Charter of Rights and Freedoms*, in particular, ss. 7 and 12, may possibly offer a patient some protection in relation to the patient's wishes regarding his or her body; R. Samek, 'Euthanasia and Law Reform' (1985) 17 *Ottawa L.Rev.* 86, 102.

¹⁰⁸ Of the dissenting judges, Brennan J. with whom Marshall J. and Blackmun J. agreed, upheld the 'fundamental right' of a person to be free of unwanted medical treatment; 111 L. Ed. 2d 224, 256-274 (1990).

¹⁰⁹ For discussion see L. Gostin, 'Life and Death Choices After Cruzan' (1991) 19 *Law, Med. & Health Care* 9; J. Bopp and T. Marzen, 'Cruzan: Facing the Inevitable' (1991) 19 *Law, Med. & Health Care* 37, 38; A. Kambouris, 'A Qualified "Right to Die": *Cruzan v Director*, Missouri Department of Health' (1991) 1 *Detroit College L.Rev.* 417. *Contra*. Annas, 54 where he states that both the right to privacy and the liberty interest delineated in the Fourteenth Amendment derive from the same source and their content in this context is unlikely to be different.

¹¹⁰ *Roe v Wade* 410 U.S. 113 (1973).

¹¹¹ J. Bopp and R.E. Coleson, 'Webster and the Future of Substantive Due Process' (1990) 28 *Duq.L.Rev.* 271, 280.

¹¹² See chapter VII, 326-330.

¹¹³ For example, *In re Conroy* 486 A. 2d 1209 (1985). Although the common law right to refuse treatment, unlike its constitutional equivalent, is not inherently limited by State interests, the courts have assumed that the exercise of the common law right must also be weighed against State interests.

¹¹⁴ The relevant State interests have been formulated by the various State courts in the United States, beginning with the seminal *In re Quinlan* case, 355 A. 2d 647 (1976), and then more comprehensively

outweighs all the relevant State interests will the right to refuse medical treatment be upheld. If, however, the court concludes that there is a State interest which overrides the patient's individual interests, the patient's request that treatment be withheld or withdrawn will be refused.¹¹⁵

In all the treatment cases coming before the courts in the United States, the courts have balanced the asserted right of the patient to reject further treatment on the one hand against the countervailing State interests on the other in order to determine whether the right of the patient should be upheld. Notwithstanding the judicial rhetoric of balancing the patient's right to refuse treatment against these countervailing State interests, up until the recent 'right to live' cases there was a fairly predictable endpoint of judicial reasoning.¹¹⁶ Although the courts have, on occasions, denied the right of a patient to refuse treatment and have ordered that treatment be administered against the patient's expressed wishes,¹¹⁷ the clear trend emerging from more recent cases is that the patient's right to refuse treatment, even life-saving treatment will be upheld.¹¹⁸

It is proposed here to briefly review the various State interests which the American courts have taken into account and to examine how the courts have dealt with these considerations.

Protection of Innocent Third Parties

One of the State interests which must be balanced against the right of an individual to refuse treatment is the State's interest in the protection of innocent third parties who may be harmed by the patient's treatment decision.¹¹⁹ The State, acting as *parens patriae* has an interest in protecting those who cannot take care for themselves. The State's interest encompasses the protection of incompetent persons and dependent third parties but has most frequently been asserted in cases involving minor children.¹²⁰ Since parents have the primary obligation of care and support for their minor children, the State has an interest in maintaining the life of the parents in order that they may continue to provide financial and emotional support to their children. Thus the court may find it necessary to override the self-determination of the parent in order to protect the children from the emotional and

outlined in *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417 (1977) and *In re Conroy* 486 A. 2d 1209 (1985). The existence of State interests which must be balanced against the individual's right to refuse treatment has also been acknowledged by the United States Supreme Court in the *Cruzan* case; 111 L. Ed. 2d 224, 242 (1990). 110

¹¹⁵ *In re Conroy* 486 A. 2d 1209, 1223 (1985).

¹¹⁶ L. Gostin, 'A Right to Choose Death: The Judicial Trilogy of *Brophy*, *Bouvia* and *Conroy*' (1986) 14 *Law, Med. & Health Care* 198. See also S. Cole and M. Shea, 'Voluntary Euthanasia: A Proposed Remedy' (1975) 39 *Alb.L.Rev.* 826, 831 where the authors suggest that the qualification of an overriding State interest is more palatable in theory than in practice.

¹¹⁷ For example, *United States v George* 239 F. Supp. 752 (1965); *In re President and Directors of Georgetown College, Inc.* 331 F. 2d 1000 (1964).

¹¹⁸ *In re Conroy* 486 A. 2d 1209 (1985); *In re Farrel* 529 A. 2d 404 (1987).

¹¹⁹ *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 425 (1977). 110.

¹²⁰ A.S. Oddi, 'The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action' (1986) 75 *Geo.L.J.* 625, 633. See, for example, *In re President and Directors of Georgetown College, Inc.* 331 F. 2d 1000 (1964); *United States v George* 239 F. Supp. 752 (1965); *In re Osborne* 294 A. 2d 372 (1972). The issue has also arisen in circumstances where the patient is pregnant and attempts are made to override the patient's refusal of treatment in order to preserve the life of the fetus. See *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson* 42 N.J. 421 (1964).

financial damage which may occur as a result of the decision of a parent to refuse life-saving treatment.

In a number of cases, the State's interest in ensuring that children will not be left parentless has been invoked by the courts to justify the imposition of medical treatment against the clearly expressed wishes of the patient.¹²¹ These cases have mainly involved the administration of blood transfusions necessary to save the life of the patient in circumstances where the patient has refused such medical treatment on religious grounds.¹²² One such example is the case of *In re President and Directors of Georgetown College, Inc.*¹²³ The Full Court of the United States Court of Appeals (District of Columbia) upheld a court order requiring the patient, a Jehovah's Witness and mother of a seven month old child, to submit to a blood transfusion which was necessary to save her life, notwithstanding the patient's objections to such treatment based upon her religious beliefs. The court based its decision in part on the ground that the State had an interest in protecting the child from the effects of abandonment.¹²⁴ The patient, in her capacity as parent, had a duty to her child as well as to the community to care for the child and could therefore be forced to accept medical treatment which would save her life.

These blood transfusion cases are perhaps distinguishable from the more usual refusal of treatment cases in that blood transfusions can be seen to represent only a temporary and minimal invasion of a patient's body and in all the cases where treatment was ordered, the prognoses for recovery was good.¹²⁵ These cases do at least demonstrate that the State has the power to enforce the treatment of a patient who is a parent of minor children, if such treatment would afford the parent complete recovery and the ability to care for his or her children.¹²⁶ However, where the patient's condition is terminal and medical treatment cannot offer a cure, application of the State interest in protecting children is clearly inappropriate.

¹²¹ For example, *In re President and Directors of Georgetown College, Inc.* 331 F. 2d 1000 (1964); *United States v George* 239 F. Supp. 752 (1965). But see Cole and Shea, 830-831 where they argue that in no case has the right to refuse treatment been denied *solely* on the basis of this State interest.

¹²² It should be noted that the refusal of treatment on religious grounds raises the issue of freedom of religion guaranteed under the First Amendment of the United States Constitution. However, as with the more general right of a patient to refuse treatment, the right to exercise one's religious beliefs must be balanced against countervailing State interests. Consequently, the approach adopted in these cases involving the refusal of treatment on religious grounds is of more general relevance. Support for this conclusion can be found in the concurring judgment of Yeagley J. in *Re Osborne* 294 A. 2d 372, 376 (1972) where he stated that his decision was not based solely on religious freedom, but also on the broader based freedom of choice whether founded on religious beliefs or otherwise.

¹²³ 331 F. 2d 1000 (1964).

¹²⁴ *Id.* 1008. The court's decision to order treatment was also in part based upon the issue of the patient's decision-making capacity.

¹²⁵ R. Hill, 'Euthanasia; The Right to Be 'Let' Alone' (1980-81) 7 *S.U.L.Rev.* 101, 103. See also *In re Quinlan* 355 A. 2d 647, 664 (1976).

¹²⁶ N. Vaughan, 'The Right To Die' (1973-4) 10 *Cal.W.L.Rev.* 613, 619. Even in circumstances where the patient refusing life-saving treatment does have dependent children, the court may nevertheless uphold the patient's refusal of treatment if it satisfied that adequate provision has been made for their future care and support; e.g. *In re Osborne* 294 A. 2d 372 (1972) in which the court upheld the right of the father to refuse life-saving treatment since he had made provision for the care and support of the children.

Even in cases where life-saving treatment is at stake, it could be argued that the State's legitimate interest in protecting the emotional and material welfare of minor children cannot justify judicial interference with a patient's decision to refuse treatment.¹²⁷ Individual interests of bodily integrity and self-determination are of such fundamental importance that they should prevail over the interests of dependent children. Significantly, in more recent cases, the courts have rejected any restriction on a patient's right to refuse treatment on the basis that he or she is a parent.¹²⁸

In addition to its concern to protect minor children from the effects of their parent's refusal of treatment, the State's interest in protecting innocent third parties extends also to wider public health considerations. Where the patient's exercise of his or her free choice could adversely affect the health, safety or security of others, the patient's right of self-determination may have to yield to the wider public interest¹²⁹ and the courts have, on occasions, required competent adults to undergo medical procedures against their will in order to protect public health.¹³⁰ There appears to be little disagreement with the view that in certain circumstances, public interest considerations, in particular, matters of public health and safety, must be given priority over individual interests.¹³¹ However, only in exceptional circumstances will the refusal of treatment by a patient have implications for the health and safety of the public.

State's Interest in the Prevention of Suicide

Another of the interests which the courts have held must be weighed against the individual's right to refuse treatment is the State's interest in the prevention of suicide.¹³² However, as a result of the approach adopted by the courts, this particular interest appears to be of little practical significance in refusal of treatment cases. On numerous occasions, the courts in the United States have held that the refusal of treatment by a patient does not amount to suicide.¹³³ This conclusion has been justified on the grounds that the patient may lack the requisite intent to die, and even if that intent was present, death would be caused, not by the patient's refusal of treatment, but as a result of the underlying condition of the patient.¹³⁴ Since the courts have consistently distinguished the refusal of treatment

¹²⁷ Lanham, 'The Right to Choose to Die with Dignity,' 420; Cantor, *Legal Frontiers of Death and Dying*, 23-24; M. Oberman, 'Withdrawal of Life Support: Individual Autonomy Against Alleged State Interests in Preserving Life' (1989) 20 *Loy.U.Chi.L.J.* 797, 803-804.

¹²⁸ For example, *Fosmire v Nicoleau* 75 N. Y. 2d 218 (1990).

¹²⁹ *In re Conroy* 486 A. 2d 1209, 1225 (1985).

¹³⁰ For example, *Jacobson v Massachusetts* 197 U.S. 11 (1905) in which the court upheld the enforceability of compulsory small pox legislation and held that the interest of a State in protecting its inhabitants from a dangerous and contagious disease outweighed the right of a person to refuse treatment.

¹³¹ See also G. Grisez and J.M. Boyle, *Life and Death with Liberty and Justice* (1979) 93; R. Byrn, 'Compulsory Life-Saving Treatment for the Competent Adult' (1975-6) 44 *Fordham L.Rev.* 1, 35.

¹³² For example, *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 425 (1977). Although this interest is perhaps better seen as part of the State's broader interest in the preservation of life (*In re Conroy* 486 A. 2d 1209, 1224 (1985)) it has generally been considered as a distinct State interest.

¹³³ *In re Quinlan* 355 A. 2d 647 (1976); *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417 (1977).

¹³⁴ *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 426 (1977). Some courts have, however, questioned this reasoning; see, for example, the dissenting judgment of Lynch J. in *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986); the Missouri Supreme Court decision, *Cruzan v Harmon*, 760 S.W. 2d 408, 411-412 (1988) per Robertson J.; and the concurring judgment of Scalia J. of the Supreme Court in the *Cruzan* case 111 L. Ed. 2d 224, 251-256 (1990).

by a patient from suicide, they have been able to find that the State's interest in the prevention of suicide does not arise in the refusal of treatment cases.¹³⁵

State's Interest in the Preservation of Life

The State's interest in the preservation of life is commonly considered to be the most significant of the four State interests.¹³⁶ It comprises two separate but related concerns: an interest in preserving the life of a particular patient and an interest in preserving the sanctity of all life.¹³⁷ Over recent years, the law in this area has undergone significant development. Although early precedent¹³⁸ can be cited in which the courts upheld the right of a patient to refuse treatment, even if death were to result, it was not until the mid 1970s, against a background of ever increasing medical capacity to sustain life, that the courts more clearly articulated the principles regarding the right to refuse treatment and its relationship with the State interest in the preservation of life. Through its development in the case law, the right of a patient to refuse treatment has been expanded to include a broadening spectrum of persons and types of treatment that may be terminated or withheld.¹³⁹

The majority of cases coming before the courts in the United States have involved incompetent patients, and it is largely within this context that the relevant principles regarding patient rights have been propounded. Since the courts have equated the rights of competent and incompetent patients,¹⁴⁰ the principles laid down in these cases are of general application to all patients. One of the major cases in the development of the patient's right to refuse treatment is the landmark decision of the Supreme Court of New Jersey in *In re Quinlan*.¹⁴¹ This case involved an application by Karen Ann Quinlan's father for the discontinuation of artificial life-support with respect to his comatosed daughter who was in a persistent vegetative state. The court, in its evaluation of the State's interest in the preservation of life, emphasised the serious and irreversible condition of the patient.¹⁴² Earlier cases in which the courts had ordered treatment were distinguished on the ground that in many of those cases the medical procedure required, (usually a blood transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good.¹⁴³ In the opinion of the court:

¹³⁵ More detailed consideration will be given to the court's approach to the suicide issue and the relationship between refusal of treatment and suicide in the following chapter, 91-95.

¹³⁶ *In re Conroy* 486 A. 2d 1209, 1223 (1985); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 32 (cited hereafter as the President's Commission Report.); G.P. Smith, 381.

¹³⁷ *In re Conroy* 486 A. 2d 1209, 1223 (1985).

¹³⁸ For example, *Erickson v Dilgard* 252 N.Y. S. 2d 705 (1962); *In re Brooks' Estate* 32 Ill. 2d 361 (1965).

¹³⁹ Oddi, 636.

¹⁴⁰ E.g. *In re Quinlan* 355 A. 2d 647, 664 (1976,); *In re Conroy* 486 A. 2d 1209 (1985); *In re Farrel* 529 A. 2d 404 (1987). Although the courts have consistently equated the rights of competent and incompetent patients, significant practical difficulties may arise with regard to the exercise of this right by an incompetent patient. As a result, in many of these cases, considerable attention has focussed on the procedural requirements and in particular, the appropriate mechanisms and safeguards for the exercise of the incompetent patient's right to refuse treatment.

¹⁴¹ 355 A. 2d 647 (1976).

¹⁴² *Id.* 663-664.

¹⁴³ *Id.* 664.

The State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individuals rights overcome the State interest.

Since Karen's prognosis was extremely poor and the degree of bodily invasion was very great,¹⁴⁴ the court concluded that there was no compelling interest of the State requiring her to endure further treatment and the court sanctioned the removal of artificial life-support.

This approach was extended further by the Supreme Court of Massachusetts in *Superintendent of Belchertown v Saikewicz*.¹⁴⁵ This case concerned a 67 year old man with severe mental retardation who had been institutionalised for most of his life. He was diagnosed as suffering from myeloblastic monocytic leukemia, an incurable and terminal condition. Medical evidence indicated that aggressive treatment of the disease was unlikely to be successful,¹⁴⁶ and was likely to cause pain and distress. As in the *Quinlan* case, the court emphasised the relevance of the patient's condition in assessing the weight to be attached to the State's interest in the preservation of life. The Supreme Court of Massachusetts found that:

There is a substantial distinction in the State's insistence that human life be saved where the affliction is incurable, as opposed to the State interest where the issue is not whether but when, for how long and at what cost to the individual that life may be briefly extended.

Thus, on the facts of the case, the court was able to conclude that the patient's right to privacy must prevail over the asserted State interest in the preservation of life.¹⁴⁷ However, the court rejected any suggestion that it was being involved in quality of life considerations.¹⁴⁸

As illustrated by the *Quinlan* and *Saikewicz* decisions, in determining whether treatment should be withheld or withdrawn, attention has frequently focussed on the condition of the patient and the degree of bodily invasion that further treatment would entail. In circumstances where the condition of the patient is terminal or beyond cure, and treatment involves significant bodily invasion, there is seen to be little conflict between, on the one hand, the interests of the individual in avoiding prolongation of the dying process and unnecessary suffering, and on the other hand, the interests of the State in the preservation of life. In such cases the courts have generally held that there is no compelling State

¹⁴⁴ The medical evidence indicated that she had no chance of being restored to cognitive or sapient life and she required 24 hour nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube.

¹⁴⁵ 370 N.E. 2d 417 (1977).

¹⁴⁶ Chemotherapy offered the possibility of achieving a remission in 30% to 50% of cases. However, the duration of the remission was estimated at between 2 to 13 months; see the report at 420.

¹⁴⁷ The decision has, however, been criticised as an unjustifiable extension of the *Quinlan* case; see, for example, S. Schultz, W. Swartz and J. Appelbaum, 'Deciding Right to Die Cases Involving Incompetent Patients: *Jones v Saikewicz*' (1977) 11 *Suffolk U.L.Rev.* 936; P. Ramsey, *Ethics at the Edges of Life* (1978) 353.

¹⁴⁸ 370 N.E. 2d 417, 432 (1977). However, by applying a 'substituted judgment' test in determining whether treatment should proceed and by having regard to the condition and prognosis of the patient, it is arguable the court did in effect give consideration to quality of life considerations. See also R. Sherlock, 'For Everything there is a Season: The Right to Die in the United States' (1982) *B.Y.U.L.Rev.* 545, 581.

interest in the preservation of life and there has been ready acceptance of the right of a patient to be free from unauthorised bodily invasion.¹⁴⁹

However, in circumstances where the death of the patient is not imminent or where the patient's life is potentially salvageable, the tension between individual and State interests arises more acutely. The State's interest in the preservation of life is, potentially at least, more significant in these circumstances, since the life of the patient is capable of preservation. On the basis of the courts approach in the *Quinlan* and *Saikewicz* which emphasises the need to balance the State's interest in the preservation of life against the condition and prognosis of the patient, it would appear that the resolution of the conflict in such circumstances would result in the interests of the patient being subordinated to the interests of the State.

Notwithstanding the significant influence of these earlier decisions, subsequent cases indicated that judicial doctrine in the United States was evolving in favour of respecting the choice of a competent patient to decline medical treatment, even in circumstances where death was not imminent and where the condition of the patient was salvageable.¹⁵⁰ This development occurred through a series of cases in which the courts in a number of United States jurisdiction rejected any suggestion that the patient's right of self-determination is dependent upon an assessment of the condition of the patient. The courts in these cases have ruled that ultimately the patient should be free to decide whether treatment should be discontinued.

The case of *Bartling v Superior Court*¹⁵¹ involved a 70 year old competent patient suffering from a number of potentially fatal conditions¹⁵² who had requested that he be removed from the life-sustaining ventilator. This request was denied by the trial judge,¹⁵³ but on appeal, the Californian Court of Appeal held that the request should have been respected, notwithstanding the fact that he had not been diagnosed as 'terminally ill'. The court held that the right to disconnect a life-support mechanism was not limited to comatose or terminally ill patients.¹⁵⁴ The court was of the view that all competent adults have the right to refuse unwanted medical treatment and held that this right outweighed societal interests, including the State interest in the preservation of life.¹⁵⁵ This

¹⁴⁹ For example, *Satz v Perlmutter* 362 So. 2d 160 (1978) (court upheld the right of a patient to refuse treatment in circumstances of unbearable pain and imminent death, finding that the patient's right to refuse treatment far outweighed the State's interest in the preservation of life); *In re Eichner* 52 N.Y. 2d 363 (1981).

¹⁵⁰ For example, *Bartling v Superior Court* 163 Cal. App. 3d 186 (1984); *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986). See also discussion by Cantor, *Legal Frontiers of Death and Dying* 19-20; G.P. Smith, 392-408.

¹⁵¹ 163 Cal. App. 3d 186 (1984). *Bartling* died on the eve of the appeal but the Californian Court of Appeal agreed to hear the case in view of the lack of guidelines regulating the conduct of hospitals in 'right to die cases'.

¹⁵² *Bartling* was suffering from cancer, emphysema, chronic respiratory failure, arteriosclerosis and an abdominal aneurysm.

¹⁵³ The lower court had refused to uphold the patient's request on the grounds that he was neither terminally ill nor permanently comatose.

¹⁵⁴ 163 Cal. App. 3d 186, 193 (1984).

¹⁵⁵ *Id.* 195-196.

development was furthered in the case of *Bouvia v Superior Court*¹⁵⁶ where the California Court of Appeal, again overruling the trial court,¹⁵⁷ upheld the request of Elizabeth Bouvia, a competent 28 year old quadriplegic, that naso-gastric feeding be discontinued. The court found that the legitimate interest of the State in preserving life may not be advanced without regard to the costs to the individual patients.¹⁵⁸ Although Elizabeth Bouvia could have possibly lived for another 15 or 20 years if appropriate feeding was ordered, the court emphasised the need to respect the patient's subjective assessment of her quality of life.¹⁵⁹

It is possible to conclude from the decisions of the appeal courts in *Bartling* and *Bouvia* that the right to refuse treatment is not dependent on the condition of the patient; whether for example the patient is permanently comatose, or terminally ill. Furthermore, the patient's *subjective* assessment of his or her quality of life and what steps are reasonable to preserve it are paramount.¹⁶⁰

An important case in the evolution of the patient's right to refuse treatment in the United States is *In re Conroy*,¹⁶¹ a decision by the same court that had determined the seminal *Quinlan* case. Ms Conroy was an elderly nursing-home patient who had serious and irreversible mental and physical impairments and a limited life expectancy. Nourishment was provided by a naso-gastric feeding tube. Ms Conroy's nephew, her only relative, petitioned the court, requesting that the naso-gastric feeding tube be removed and that she be allowed to die. This request was granted at first instance,¹⁶² but an appeal by Ms Conroy's guardian *ad litem* resulted in this decision being reversed by the Appellate Division of the Superior Court.¹⁶³ On appeal to the New Jersey Supreme Court, the court upheld the paramountcy of the patient's right to refuse treatment stating that on balance, the right to self-determination ordinarily outweighs any countervailing State interests.¹⁶⁴ Whilst acknowledging the strength of the State's interest in preserving the life of a particular patient as well as the sanctity of all life, the court held that these interests will not in themselves usually foreclose a competent person from declining life-sustaining medical treatment for him or herself. As was explained by the court, this is because the life that the State is seeking to protect in such a situation is the life of the same person who has competently decided to forgo the medical intervention: it is not some other actual or potential life that cannot adequately protect itself.

¹⁵⁶ 225 Cal. Rptr. 297 (1986).

¹⁵⁷ The trial judge had based his decision on the grounds that the patient was not terminally ill and had a life expectancy of 15-20 years and that force-feeding was justified on a non-terminal patient; *Bouvia v County of Riverside, Riverside County* (Cal.) Sup. Ct. Case No. 159780 (1983). See V. Gilbreath, 'The Right of the Terminally Ill to Die with Assistance if Necessary' (1986) 8 *Crim.Just.J.* 403, 408.

¹⁵⁸ 225 Cal. Rptr. 297, 304-05 (1986).

¹⁵⁹ *Id.* 305.

¹⁶⁰ See G. Annas, 'Transferring the Ethical Hot Potato' (1987) 17 *Hastings Center R.* 20.

¹⁶¹ 486 A. 2d 1209 (1985).

¹⁶² 457 A. 2d 1232 (1983).

¹⁶³ 464 A. 2d 303 (1983). Ms Conroy had in fact died with her naso-gastric feeding tube still in place prior to the hearing of the matter but the court agreed to proceed with the case on the grounds that it raised a matter of substantial importance, capable of repetition but which appeared to evade review.

¹⁶⁴ 486 A. 2d 1209, 1225 (1985).

Although the case before the court involved an incompetent patient with a limited life expectancy,¹⁶⁵ the court made it clear that if Ms Conroy were competent, her right to self-determination would not be affected by her medical condition or prognosis.¹⁶⁶ The court stated that a young, generally healthy person has the same right to decline life-saving medical treatment as a competent elderly person who is terminally ill. Further, the court specifically rejected judicial reliance upon a qualitative assessment of the patient's life in determining whether to uphold a decision of a competent patient to refuse treatment. Whilst acknowledging that a patient's decision to accept or reject medical treatment may be influenced by his or her medical condition, treatment and prognosis, the court held that a competent person's right to refuse medical treatment does not depend on the quality or value of his or her life.¹⁶⁷

The rejection of quality of life considerations by the court in determining refusal of treatment cases is significant. It heralds judicial recognition that it is inappropriate for a court to determine whether to uphold a patient's decision to refuse treatment on the basis of whether or not the court finds that the patient's life is worth preserving. Indeed, this represents the major criticism of the position underlying some of the earlier cases which had emphasised the condition and prognosis of the patient and nature of treatment in determining whether the individual interests should yield to the State's interest in the preservation of life. The difficulty with this earlier approach is that it appears to involve the court in an objective assessment of the person's quality of life and whether that life is worth living.¹⁶⁸ Implicit in this analysis is the assumption that only if the person's life is worth preserving will the State interest outweigh the right of the individual to refuse treatment. For the courts to be involved in this kind of assessment is clearly objectionable on policy grounds, since it creates a vague, invidious and perilous criterion on which to decide whether to comply with a patient's refusal of treatment.¹⁶⁹ It was this realisation which led the New Jersey Supreme Court in *In re Conroy* to reject any distinction based upon the condition or prognosis of the patient or the patient's quality or value of life.¹⁷⁰ As was recognised by that court, the only acceptable alternative is to respect the decisions of all competent patients regarding the withholding or withdrawal of treatment, based upon the patient's own subjective assessment.¹⁷¹ This clearly involves giving priority to individual rights over the State's interests in the preservation of life.

¹⁶⁵ *Id.* 1219 where the question for the courts determination was stated to be 'the circumstances under which life-sustaining treatment may be withheld or withdrawn from an elderly nursing-home resident who is suffering from serious and permanent mental and physical impairments, who will probably die within approximately one year even with treatment and who, though formerly competent, is now incompetent to make decisions about her life-sustaining treatment and is unlikely to regain such competence.'

¹⁶⁶ *Id.* 1226.

¹⁶⁷ *Id.* 1226.

¹⁶⁸ Lanham, 'The Right to Choose to Die with Dignity,' 417.

¹⁶⁹ *Id.* 418; Cantor, *Legal Frontiers of Death and Dying* 20; K. Hegland, 'Unauthorised Rendition of Lifesaving Medical Treatment' (1965) 53 *Calif.L.Rev.* 860, 872.

¹⁷⁰ Cantor, *Legal Frontiers of Death and Dying* 20. Where, however, decisions have to be made on behalf of incompetent patients on the basis of the 'limited objective' and 'pure objective tests' established in *In re Conroy* 486 A. 2d 1209 (1985) quality of life considerations cannot be entirely avoided; S. Levant, 'Natural Death: An Alternative in New Jersey' [1985] 73 *Geo.L.J.* 331, 1337.

¹⁷¹ This was the approach adopted in the case of *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986) considered above, 55. The patient's decision will no doubt be influenced by quality of life considerations but this is quite a different matter from the courts making such an assessment; *In re Conroy* 486 A. 2d 1209, 1226 (1985); Cantor, *Legal Frontiers of Death and Dying* 53-57.

A more recent decision of the New Jersey Supreme Court which confirms and consolidates the approach taken in *In re Conroy* is *In re Farrel*, one of a trilogy of cases decided by the court on the same day.¹⁷² Kathleen Farrel, a competent 37 year old woman suffering from an incurable condition (Lou Gehrig's disease), had requested that the mechanical ventilator that sustained her breathing be disconnected. When her doctor refused to comply with this request, her husband applied to the court seeking an order that treatment be discontinued. The New Jersey Supreme Court upheld the right of patients to make decisions regarding their own treatment:

In the case of a competent adult patient, it is primarily that person who should make the decision. A competent person's interest in her or his self-determination generally outweighs any countervailing interest the State may have.¹⁷³

The court continued:

All patients, competent or incompetent, with some limited cognitive ability or in a persistent vegetative state, terminally ill or not terminally ill, are entitled to choose whether or not they want life-sustaining medical treatment... Medical choices are private... They are not to be decided by societal standards of reasonableness or normalcy. Rather it is the patient's preferences - formed by his or her unique personal experiences - that should control. The privacy that we accord medical decisions does not vary with the patient's condition or prognosis.¹⁷⁴

The court emphasised, however, that in cases of this nature, there must be some procedural safeguards to ensure that the patient is competent and informed about the prognosis, alternative treatments available and the risks involved in terminating the life-sustaining treatment and that the patient's decision is made voluntarily and without coercion.¹⁷⁵

The judgment in this case, (one of the few cases dealing with a competent patient) represents one of the clearest statements recognising the patient's right to refuse treatment. It unequivocally affirms the right of a patient to refuse treatment regardless of the patient's condition or prognosis and asserts the primacy of this right over countervailing State interests, including the State's interest in the preservation of life.¹⁷⁶

¹⁷² 529 A. 2d 404 (1987). The other two cases, involving incompetent patients, were *In re Peter by Johanning* 529 A. 2d 419 (1987); *In re Jobes* 529 A. 2d 434 (1987).

¹⁷³ *Id.* 416.

¹⁷⁴ *In re Peter by Johanning* 529 A. 2d 419, 423 (1987) (decided by the same court on the same day.)

¹⁷⁵ 529 A. 2d 404, 413 (1987).

¹⁷⁶ There have been a number of other cases involving non-terminal competent patients; e.g. *In re Rodas*, District Court, County of Mesa, State of Colorado, No. 86 P.R. 139, 22 Jan. 1987; *Georgia v McAfee*, Georgia Supreme Court, 21 Nov. 1989; *McKay v Bergstedt*, No. 21207, Nevada Supreme Court, 30 Nov. 1990, 59 U.S.L.W. (General) 2364, 18 Dec. 1990. Although the principles in these cases have been stated to apply to both competent and incompetent patients, (e.g. *In re Conroy* 486 A. 2d 1209 (1985); *In re Farrel* 529 A. 2d 404 (1987)), in practice, the application of these principles with respect to incompetent patients may prove problematic, particularly in cases where there is no indication of the patient's prior wishes. In such circumstances, where a decision must be made on behalf of an incompetent patient, it may be impossible to avoid consideration of the patient's condition and general quality of life considerations. See also Cantor, *Legal Frontiers of Death and Dying*, 56-57; Levant, 1337. Examination of decision-making for incompetent patients is beyond the scope of this thesis.

Although the majority of cases have followed this trend, upholding the principles of patient autonomy and self-determination over countervailing interests in the preservation of human life, there have been a few isolated cases which appear to have gone against the mainstream.¹⁷⁷ All of these cases have involved incompetent patients dependent on artificial nutrition and hydration and the courts have strongly asserted the State's interest in the preservation of life, refusing to authorise the withdrawal of these measures.

The decision of the Missouri Supreme Court in the *Cruzan* case is illustrative of these 'right to live' cases.¹⁷⁸ As a result of a motor vehicle accident Nancy Cruzan, a 30 year old woman, was in a persistent comatose and vegetative state. After five years of nursing home care there was no indication of improvement in her condition, and her parents, in their capacity as court appointed guardians, sought the discontinuance of nutrition and hydration which was being provided through a gastronomy feeding tube. The hospital refused to comply with the parent's direction in the absence of a court order. The parents consequently initiated proceedings against the Director of the Missouri Health Department and the hospital administrator seeking a declaratory judgment to sanction the treatment withdrawal. After hearing evidence about the patient's circumstances, including testimony from family and friends about statements she had made to the effect that she would not wish to continue living in such a state, the trial court upheld the parent's request for the withdrawal of medical treatment, including the feeding tube.

On appeal, the Missouri Supreme Court, by a narrow majority, reversed the trial court's decision.¹⁷⁹ Whilst recognising the right of a patient to refuse medical treatment based on the common law doctrine of informed consent,¹⁸⁰ the court found that the State of Missouri had a strong policy favouring the preservation of life, as embodied in the Missouri living will statute.¹⁸¹ Because the withdrawal of nutrition and hydration would result in death, the court held that the State of Missouri, in exercise of its interest in the preservation of life, was entitled to regulate such decisions by requiring 'clear and convincing evidence' of the patient's wishes before treatment would be withdrawn.¹⁸² Since the court was not satisfied that such evidence existed, the request for the withdrawal of the feeding tube was refused.

However, the decision of the court, particularly with regard to the State's interest in the preservation of life, went beyond what was necessary to decide the case on its facts. The court ruled that the State's interest in the preservation of life, particularly valid in circumstances where the patient is not

¹⁷⁷ See, for example, the Washington Supreme Court decision in *In re Grant* 109 Wash. 2d 545 (1987); the New York Court of Appeals in *In re Westchester County Medical Center (O'Connor)* 72 N.Y. 2d 517 (1988); and the Missouri Supreme Court in *Cruzan v Harmon* 760 S.W. 2d 408 (1988). There have also been strong dissenting judgments in a number of other cases; see, for example, *In re Gardner* 534 A. 2d 947 (1987); *Brophy v New England Sinai Hosp. Inc.* 497 N.E. 2d 626 (1986).

¹⁷⁸ This terminology comes from J. Bopp and J.D. Avila, 'Trends in the Law from Death to Life' (1990-91) 27 *Idaho L.Rev.* 1, 3.

¹⁷⁹ *Cruzan v Harmon* 760 S.W. 2d 408 (1988) by a majority of 4:3.

¹⁸⁰ *Id.* 416-417.

¹⁸¹ Mo. Rev. Stat 459.010 et seq, 1986.

¹⁸² *Id.* 425-427.

terminally ill, is 'unqualified' and under the circumstances, outweighed the patient's right to refuse treatment. Consistent with the earlier cases outlined above,¹⁸³ the court rejected any quality of life considerations but chose instead to devise its own formula based on the assessment of the patient's life expectancy balanced against the extent of the treatment burden.¹⁸⁴ The court held that:

Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment ...outweighs the immense, clear fact of life in which the State maintains a vital interest.¹⁸⁵

The decision of the Missouri Supreme Court is significant because it is the first case in modern American jurisprudence in which treatment was ordered explicitly on the basis of the State's interest in the preservation of life, rather on the basis of the patient's wishes or best interests.¹⁸⁶ The decision has, as a result, drawn sharp criticism from a number of quarters.¹⁸⁷ In analysing the significance of the decision, there is a temptation to confine its application to the facts of the case; i.e. a case of withdrawal of nutrition and hydration¹⁸⁸ from an incompetent patient whose wishes were not established to the satisfaction of the court.¹⁸⁹ However, the reasoning adopted by the Missouri Supreme Court strongly suggests that the revived State interest in the preservation of life would apply also to competent patients who had expressed their wishes about medical treatment.¹⁹⁰

The United States Supreme Court granted *certiorari* and upheld the decision of the Missouri Supreme Court by a majority of five to four.¹⁹¹ As noted earlier,¹⁹² the question before the Supreme Court was framed in very narrow terms; whether the procedural requirement imposed by the State of Missouri of 'clear and convincing evidence' of an incompetent patient's previously expressed wishes as a precondition to the withdrawal or withholding of treatment was unconstitutional.¹⁹³ Whilst

¹⁸³ See above, 55-57.

¹⁸⁴ *Id.* 420, 422-424. See also P. Peters, 'The State's Interest in the Preservation of Life: From *Quinlan* to *Cruzan*' (1989) 50 *Ohio St.L.J.* 891, 905-907.

¹⁸⁵ 760 S.W. 2d 408, 424 (1988).

¹⁸⁶ Peters, 905. For an early example of a court subordinating a patient's right to refuse treatment to the State's interest in the preservation of life, see *John F. Kennedy Memorial Hospital v Heston* 58 N.J. 576 (1971).

¹⁸⁷ See, for example, R. McCormick, 'The *Cruzan* Decision' (1990) Vol. 9 No. 2 *Bioethics News* 16; Peters, 905-910.

¹⁸⁸ The issue of withdrawal of nutrition and hydration is dealt with in more detail below, 61-64.

¹⁸⁹ It could be argued that the *Cruzan* case has justifiably cast doubt on reliance upon principles of autonomy and self-determination in respect of incompetent patients, at least in circumstances where the patient has never been competent, or in respect of formerly competent patients who have not clearly expressed their treatment preferences. For discussion see S. Johnson, 'From Medicalization to Legalization to Politicization: *O'Connor*, *Cruzan* and the Refusal of Treatment in the 1990s' (1989) 21 *Conn.L.Rev.* 685. A full examination of decision-making for incompetent patients is, however, beyond the scope of this thesis.

¹⁹⁰ See discussion by Peters, 908-909; L. Albert, '*Cruzan v Director, Missouri Department of Health*' (1991) 12 *J. Legal Med.* 331, 355-356; Johnson. In this respect the decision arguably goes further than the earlier 'right to live' cases referred to above, 58.

¹⁹¹ Chief Justice Rehnquist delivered the majority opinion, in which Justices White, O'Connor, Scalia, and Kennedy joined. Justices O'Connor and Scalia also delivered separate concurring opinions to further express their views. Justice Brennan filed a dissenting opinion in which Justices Marshall and Blackmun joined. Justice Stevens filed a separate dissenting opinion.

¹⁹² See above, 47-48.

¹⁹³ 111 L. Ed. 2d 224, 241, 243 (1990).

affirming the right of a competent patient to refuse treatment,¹⁹⁴ the Supreme Court held that since States have an interest in protecting and preserving life, they are entitled to regulate the exercise of that right, particularly with regard to incompetent patients. The court recognised that where a patient is incompetent, States have a legitimate interest in protecting the patient's life and ensuring through heightened evidentiary standards, that the decision to terminate life-sustaining treatment reflected the patient's actual preferences.¹⁹⁵ The court went on to hold that the requirement under Missouri law of 'clear and convincing evidence' of an incompetent patient's wishes was a legitimate form of State regulation not contrary to the United States Constitution.¹⁹⁶

The implications of the Supreme Court decision in the *Cruzan* case must be carefully assessed. Although affirming the decision of the Missouri Supreme Court, the question addressed by the United States Supreme Court was narrowly framed in terms of the constitutionality of the procedural requirement imposed by the State of Missouri in respect of incompetent patients.¹⁹⁷ The effect of the Supreme Court's ruling is that States are largely free to determine their own procedural safeguards in relation to the withholding or withdrawing of medical treatment from incompetent patients. The decision is of more limited relevance to the general issue of the right of patients to refuse medical treatment. The Supreme Court did acknowledge the right of a competent patient to refuse treatment as a constitutionally protected liberty interest. In accordance with earlier decisions, the court held that this right is not absolute and must be weighed against relevant State interests including the State's interest in the preservation of life. The court did not, however, specifically address the issue of the appropriate weight to be given to the State's interest in the preservation of life, particularly when this is balanced against the right of a competent patient to refuse treatment.¹⁹⁸

In light of the Missouri Supreme Court decision in the *Cruzan* case, and a number of other similar cases, it can no longer be stated with certainty that a patient's right to refuse treatment will necessarily prevail over the State's interest in the preservation of life. The full implications of this line of cases has yet to be determined. Whilst some commentators have sought to dismiss this line of authority as an aberration¹⁹⁹ against the mainstream view, others see this case as a significant and growing challenge to an individual's right to refuse treatment.²⁰⁰ However, care must be taken not to overstate the significance of this development. Mainstream judicial doctrine in the United States, which has, implicitly at least, been affirmed by the Supreme Court decision in the *Cruzan* case, is still firmly in

¹⁹⁴ *Id.* 241-242.

¹⁹⁵ *Id.* 243-244.

¹⁹⁶ *Id.* 244-246.

¹⁹⁷ Consideration of other aspects of the Supreme Court's decision concerning decision-making in respect of incompetent patients, (including the ruling that the Due Process Clause does not require a State to accept the 'substituted judgment' of close family members in the absence of substantial proof that their views reflect the views of the patient 111 L. Ed. 2d 224, 246-247 (1990)), are beyond the scope of this thesis.

¹⁹⁸ The only comment in the case to suggest that a State may assert a strong interest in the preservation of life, even where the patient is competent, was at 111 L. Ed. 2d 224, 243 (1990) where the view was expressed by the Chief Justice to the effect that a State need not remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.

¹⁹⁹ See discussion by Bopp and Avila, 4.

²⁰⁰ For example, Johnson, 686.

favour of respecting patient autonomy and giving priority to the patient's right to refuse treatment over any interest that the State may have in preserving the life of that patient.²⁰¹ It could, however, be argued, particularly in the wake of the more recent 'right to live' cases, that there is a need for clearer analysis of the underlying values served by the State's interest in the preservation of life in order for the courts to be able to determine the weight to be assigned to this State interest in relation to the patient's right to refuse treatment.²⁰²

Nutrition and Hydration as Medical Treatment

Although the question of nutrition and hydration has, indirectly at least, already been dealt with in the foregoing discussion,²⁰³ it is proposed to give this matter separate consideration, in view of the controversy surrounding this issue.

If a patient is no longer able to orally take nutrition and hydration, these requirements will have to be administered artificially. This can be done in a variety of ways including intravenous infusions, through a naso-gastric tube, a gastrostomy tube or a jejunostomy tube.²⁰⁴ The question which arises is whether the provision of artificial nutrition and hydration can be characterised as medical treatment, and if so, whether a patient has the right to reject such procedures.

The issue of withholding or withdrawing of artificial nutrition and hydration from a patient has given rise to considerable debate and controversy. Some commentators take the view that the provision of such basic bodily needs goes beyond the realm of medical treatment which can be withheld or withdrawn from a patient.²⁰⁵ On the other hand, the provision of artificial nutrition and hydration is regarded by some as a basic, non-negotiable form of ordinary routine care which should be provided so long as the patient is alive.²⁰⁶ To a large extent, this belief appears to be based upon the emotional and symbolic significance commonly associated with the provision of nutrition and hydration.²⁰⁷ The feeding of a patient is seen to be an expression of care and compassion which sets it apart from other forms of treatment²⁰⁸ and consequently there has been a reluctance in some quarters in condoning the

²⁰¹ For commentators in support of this development, see Cantor, *Legal Frontiers of Death and Dying*, 19-20; G.P. Smith, 408; Annas, 'Transferring the Ethical Hot Potatoe,' 21. Note also the President's Commission Report, 32.

²⁰² See Peters, also for analysis of the possible values or purposes that may give the State an interest in the preservation of a patient's life.

²⁰³ In particular, in the context of the cases such as *In re Conroy* 486 A. 2d 1209 (1985); *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986); and *Cruzan v Director, Missouri Department of Health* 111 L. Ed. 2d 224 (1990) involving the withdrawal of artificial feeding.

²⁰⁴ D. King *et al*, 'Where Death Begins While Life Continues' (1990) 31 *S.Tex.L.Rev.* 145, 168.

²⁰⁵ For example, G. Meilaender, 'On Removing Food and Water: Against the Stream' (1980) 14 *Hastings Center R.* 11.

²⁰⁶ See Meilaender; S. Helsper and J. McCarthy, 'Forgoing Artificial Nutrition and Hydration: Some Recent Legal and Moral Implications for Catholic Health Care Facilities' (1987) 54 *Linacre Q.* 39.

²⁰⁷ J. Lynn and J. Childress, 'Must Patients Always be Given Food and Water?' (1983) 13 *Hastings Center R.* 17; R. Dresser and E. Boisaubin, 'Ethics, Law and Nutritional Support' (1985) 145 *Arch. Internal Med.* 122; B. Lo and L. Dornbrand, 'The Case of Claire Conroy: Will Administrative Review Safeguard Incompetent Patients?' (1986) 104 *Annals Internal Med.* 869; A. Capron, 'Care of the Dying: Withholding Nutrition' (1984) 14 *Hastings Center R.* 32; D. Callahan, 'On Feeding the Dying' (1983) 13 *Hastings Center R.* 22.

²⁰⁸ See, for example, Cantor, 'Conroy, Best Interests and the Handling of Dying Patients,' 542 where he considers this particular argument.

withholding or withdrawing of such care.²⁰⁹ Furthermore, concern has been expressed that if a patient dies following the withdrawal of nutrition or hydration, the cause of death is starvation or dehydration rather than death from natural causes.²¹⁰ This has given rise not only to questions of criminal liability for the withholding or withdrawing of artificial nutrition and hydration²¹¹ but has also raised fundamental questions about its moral permissibility.

Notwithstanding the special significance which is often associated with the provision of nutrition and hydration, there is a growing consensus in both medical and legal circles in support of the view that there is no valid distinction between the provision of nourishment and other forms of life-support and that in appropriate circumstances, such procedures can be withheld or withdrawn.²¹²

In recent years, this issue has arisen for judicial consideration on a number of occasions, primarily in the context of care of incompetent patients. An important case in this area was that of *Barber v Superior Court*²¹³ in which the Californian Court of Appeal unequivocally ruled that artificial nutrition was to be treated like other forms of artificial life-support and could be withdrawn where it was demonstrated to be of no benefit to the patient. In this case two doctors were charged with murder. The doctors had, at the request of the family, removed first the respirator and then intravenous tubes from Clarence Herbert who was in a permanently comatose state. Whilst recognising the emotional symbolism of providing food and water,²¹⁴ the court refused to distinguish between artificial nutrition and hydration and other forms of artificial life-support. The court was of the view that:

Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration. Their benefits and burdens ought to be evaluated in the same manner as any other medical procedure.²¹⁵

Thus, it was held, in circumstances where the patient was in a comatose state, from which any meaningful recovery of cognitive brain function was exceedingly unlikely, the treating doctors were,

²⁰⁹ For example, Meilaender. There have also been objections founded on religious grounds; e.g. D. McCarthy, 'Murder by Deprivation of Medical Treatment' (1983) 8 *Ethics and Medics* 3; Helsper and McCarthy.

²¹⁰ See Cantor, *Legal Frontiers of Death and Dying*, 39-40 where he raises and dismisses this objection. See also Lynn and Childress, 20.

²¹¹ For example, *Barber v Superior Court* 195 Cal Rptr. 484 (1983).

²¹² See Statement of the Council of Judicial and Ethical Affairs of the American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment* March (1986) (which recognised that a physician may ethically withdraw all means of life-prolonging medical treatment, including nutrition and hydration, from patients who are terminally ill or who are in irreversible comas); Hastings Center Report *Guidelines on the Termination of life-Sustaining Treatment and Care for the Dying* (1987) 60-62; S. Wanzel *et al*, 'The Physician's Responsibility to the Hopelessly Ill Patient' (1984) 310 *New Eng.J.Med.* 955, 958; and the President's Commission Report, 90 (where the commission acknowledged that no particular treatments are universally warranted and thus obligatory for a patient to accept.)

It should be noted that under many of the 'living will' acts in the United States, nutrition is either explicitly excluded from the types of life-prolonging treatment which may be rejected through an advance directive, or the circumstances in which nutrition may be withdrawn are circumscribed. See N. Cantor, 'The Permanently Unconscious Patient, Non-Feeding and Euthanasia' (1989) 15 *Am.J.L. & Med.* 381, 386-387. For further discussion, see chapter VII, 328.

²¹³ 195 Cal Rptr. 484 (1983).

²¹⁴ *Id.* 490.

²¹⁵ *Ibid.*

for the purposes of the criminal law, under no legal duty to continue medical nourishment and hydration, notwithstanding that the patient's death would result.

Another case which has been influential in this area is *In Re Conroy*²¹⁶ (considered above²¹⁷) which was the first case in which a State Supreme Court recognised that the right to refuse treatment encompasses the right to refuse artificial nutrition and hydration. As in the earlier *Barber* case, the New Jersey Supreme Court acknowledged the emotional symbolism of food but held that artificial feeding such as naso-gastric tubes and intravenous infusions are medical procedures with risks and side effects. Accordingly, the court ruled that the withdrawal of artificial feeding, like any other medical treatment, would be permissible in appropriate circumstances.²¹⁸ In the opinion of the court:

Analytically, artificial feeding by means of a naso-gastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.²¹⁹

The court went on to make it clear that a competent patient has the right to decline any medical treatment, including artificial feeding, and should retain that right when and if he or she becomes incompetent.²²⁰

The tragic case of Elizabeth Bouvia, also noted above,²²¹ is further confirmation of the judicial trend towards upholding the right of a patient to refuse artificial nutrition and hydration in the same way that he or she can refuse all other medical treatments and procedures. In an application brought by Ms Bouvia for the discontinuance of naso-gastric feeding, the Californian Court of Appeal, reversing the decision of the trial judge, upheld the right of a competent adult to refuse any treatment or medical service, even though such treatment could be classified as nourishment and hydration and notwithstanding that the exercise of that right could create a life-threatening condition.

Although in the majority of cases, the courts have characterised artificial feeding as a form of medical treatment equivalent to other forms of artificial life-support,²²² in a number of cases, the courts have rejected this approach.²²³ One of the more publicised instances where a court refused to authorise the withdrawal of artificial feeding was the decision of the Missouri Supreme Court in the *Cruzan* case.

²¹⁶ 486 A. 2d 1209 (1985).

²¹⁷ See above, 55-56.

²¹⁸ *Id.* 1235-1236.

²¹⁹ *Id.* 1236.

²²⁰ *Ibid.*

²²¹ See above, 55.

²²² See also *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986); *In re Peter by Johanning* 529 A. 2d 419 (1987); *In re Jobes* 529 A. 2d 434 (1987).

²²³ See, for example, *In re Grant* 109 Wash. 2d 545 (1987); *In re Westchester County Medical Center (O'Connor)* 72 N.Y. 2d 517 (1988); *Cruzan v Harmon* 760 S.W. 2d 408 (1988); and the strong dissents in a number of other cases; e.g. Lynch J. in *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986). For commentators who have been critical of the courts approach in treating nutrition and hydration as a form of medical treatment, see, for example, J. Bopp, 'Nutrition and Hydration for Patients: The Constitutional Aspects' (1988) 4 *Issues Law & Med.* 3; Y. Kamisar, 'The Right to Die' (1988) 33 *Mich.L. Quadrangle News* 7, 7-8.

The court sought to distinguish artificial nutrition and hydration from medical treatment, on the basis that 'common sense tells us that food and water do not treat illness, they maintain a life'.²²⁴ However, according to the court, the issue was not whether the continued feeding was medical treatment but rather, whether the procedure was a burden to the patient.²²⁵ Since the provision of artificial nutrition and hydration was not, in the court's opinion, invasive or oppressively burdensome, and in view of the patient's long life expectancy, the court held that the State's interest in the preservation of life outweighed the patient's right to refuse treatment.

The decision of the United States Supreme Court in the *Cruzan* case was, however, more in accordance with mainstream authority. Some members of the court specifically held that artificial feeding is a form of medical treatment, and that therefore, an individual's decision to reject artificially delivered food and water was encompassed within the constitutionally protected liberty interest.²²⁶ This proposition was implicitly accepted by the majority of the court.²²⁷ In the light of this decision, it is arguable that living will legislation which purports to treat artificial nutrition and hydration differently from other life-sustaining interventions may be unconstitutional.²²⁸ The Supreme Court did, however, recognise that from a practical point of view, the decision to withhold nutrition and hydration was one of obvious finality and therefore the States were entitled to take an active role in the regulation of such decisions.

In sum, the position is that despite a few notable exceptions, in the majority of cases, the courts have classified artificial nutrition and hydration as a form of medical treatment which a patient is entitled to forgo. If the principles of patient autonomy and self-determination are to be consistently applied, it would logically follow that the patient's right to refuse nutrition and hydration is not confined to circumstances where nourishment is provided by artificial means, but includes cases where a patient refuses oral feeding.²²⁹ Whilst there is, to date, no case law in the United States directly on point, this appears to be the direction in which the courts are advancing.

Ordinary and Extraordinary Treatment

Attempts have also been made to curtail the right of a patient to refuse treatment by reference to the theological distinction between 'ordinary' and 'extraordinary' means.²³⁰ According to traditional

²²⁴ 760 S.W. 2d 408, 423 (1988). For criticism of this aspect of the court's decision, see McCormick, 21-22.

²²⁵ *Ibid.*

²²⁶ See O'Connor J., concurring judgment, 111 L. Ed. 2d 224, 247-251 (1990) and the dissenting judgment of Brennan J. with whom Marshall J. and Blackmun J. joined; 256-274.

²²⁷ It was assumed by the majority, for the purposes of the decision, that the constitutionally protected liberty interest for competent persons includes the right to refuse life-saving hydration and nutrition; see Rehnquist C.J. 242.

²²⁸ See also G. Annas, 'Nancy Cruzan and the Right to Die' (1990) 323 *New Eng.J.Med.* 670, 671; F. Rouse, 'Advance Directives: Where are We Heading After *Cruzan*?' (1990) 18 *Law, Med. & Health Care* 353.

²²⁹ See also Cantor, *Legal Frontiers of Death and Dying*, 43-44.

²³⁰ For discussion of the historical background of this distinction, see the President's Commission Report, 82-89; J. McCartney, 'The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case' (1981) 45 *Conn.Med.* 725.

Catholic teaching, an individual is morally obliged to use ordinary means²³¹ to preserve his or her life but there is no obligation to use extraordinary means.²³² Attempts have been made to convert this theological distinction into one of legal significance with some commentators arguing that the patient's legal right to refuse treatment only applies to the refusal of 'extraordinary' treatment and does not extend to the refusal of 'ordinary' treatment.²³³ Although the courts in the United States have, on occasion, made reference to this distinction,²³⁴ it has never been fully accepted for legal purposes and in more recent times it has been almost universally rejected.²³⁵ It is now widely recognised that there are enormous difficulties inherent in the ordinary and extraordinary means dichotomy, particularly with respect to its application in practice.²³⁶

Accordingly, any argument that the patient's right to refuse treatment only applies to ^{extra-}ordinary treatment and does not extend to ~~extra~~ordinary treatment simply lacks foundation. Apart from its theological source, there is no authority to support such an argument, and particularly in view of the difficulties inherent in the distinction, it must be concluded that it is neither a sound nor an appropriate basis for determining the extent of a patient's right to refuse treatment. MO.

Notwithstanding the challenge from the Missouri Supreme Court in the *Cruzan* decision, on the basis of mainstream case law in the United States, a competent patient has the right to refuse any treatment, even life-saving treatment. Although the courts in the United States have recognised that the State has a legitimate interest in the preservation of life, in most cases, this State interest is not regarded as sufficiently compelling to override the patient's right to refuse treatment. Indeed, since most courts have held that a competent patient has the right to refuse *any* treatment, even life-saving treatment,

²³¹ 'Ordinary means' of preserving life have been defined as all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience; G. Kelly, 'The Duty to Preserve Life' (1951) 12 *Theological Studies* 550.

²³² 'Extraordinary means' are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which if used, would not offer a reasonable hope of benefit; Kelly.

²³³ See, for example, B. Dickens, 'The Right to a Natural Death' (1981) 26 *McGill L.J.* 847, 856-862, 868, 876.

²³⁴ For example, in the cases of *In re Quinlan* 355 A. 2d 647, 667-678 (1976); *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 423 (1977); *Brophy v New England Sinai Hosp. Inc.* 497 N.E. 2d 626, 637 (1986). As Cantor points out, (*Legal Frontiers of Death and Dying* 35), whilst many of the judicial opinions in the area of death and dying have mouthed this formula, they have generally not analysed its meaning nor applied its limitation. MO.

²³⁵ The ordinary/extraordinary distinction has been unequivocally rejected in a number of cases (e.g. *In re Conroy* 486 A. 2d 1209, 1234-1235 (1985); *Barber v Superior Court* 195 Cal. Rptr. 484, 491-492 (1983)); as well as by a significant body of recognised commentators (e.g. Ramsey, 153; Cantor, *Legal Frontiers of Death and Dying*, 35; G.P. Smith, 345-350) and law reform organisations (e.g. the President's Commission, see the President's Commission Report, 88-89.) Significantly, there appears to have been some reconsideration of the terms of this distinction, even within the Catholic Church itself. In the Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Vatican City (1980) 10-11 the distinction between ordinary and extraordinary means was replaced by the concepts of 'proportionate and disproportionate means.'

²³⁶ For example, in *In re Conroy* 486 A. 2d 1209, 1235 (1985) the court was of the view that the term 'extraordinary' 'has too many conflicting meanings to remain useful' and suggested that 'to draw a line on this basis for determining whether treatment should be given leads to a semantic milieu that does not advance the analysis'.

regardless of the condition and prognosis of the patient,²³⁷ they have effectively elevated the individual interests of patients above the State's interest in the preservation of life.

State's Interest in Maintaining the Ethical Integrity of the Medical Profession

The final interest of the State which must be balanced against the individual's right to refuse treatment is the State's interest in preserving the ethical integrity of the medical profession. Traditionally, the role of the medical profession has been to save and prolong life and doctors are, in certain circumstances, under a legal and ethical obligation to provide treatment to their patients. Thus the refusal by a patient of life-saving treatment may pose legal and ethical difficulties for the medical profession. Particularly in more recent times, there has been a very real concern expressed in medical circles that if treatment is withheld, and a patient dies as a result, civil or even criminal liability may result. Moreover, compliance with the patient's request to terminate treatment may be contrary to the ethical standards of the medical profession and may even attract sanctions for unprofessional conduct.²³⁸ Consequently, it has been held that, in weighing up the right of an individual to refuse treatment, the courts must take into account the need to preserve the ethical integrity of the medical profession. There appears, however, to be widespread agreement that this State interest is not sufficiently compelling to justify overriding the patient's right to refuse treatment. Whilst the concerns of the medical profession regarding potential civil or even criminal liability arising from the withholding or withdrawal of treatment are indeed understandable, they do not constitute a valid basis for a court to deny the right of a patient to refuse treatment.²³⁹ With regard to the need to safeguard the ethical integrity of the medical profession, the view has generally been taken that ethical standards are not in fact compromised by adhering to the request of a patient to refuse treatment.

One of the first cases to raise this issue was *In re Quinlan*²⁴⁰ considered earlier,²⁴¹ in which one of the claimed interests of the State was the defence of the right of the doctor to administer medical treatment according to his best judgment.²⁴² There was evidence from the doctors in that case to the effect that removing Karen from the respirator would conflict with their professional judgment and prevailing medical standards.²⁴³ Although the court acknowledged this particular interest, the view was taken that in an action for declaratory relief, the court had a non-delegable judicial responsibility to review the doctor's decision in order to preserve underlying human values and rights.²⁴⁴ The court was of the view that the state of the pertinent medical standards which had guided the attending doctor in declining to withdraw the respirator from the patient, was not such as to justify the court in

²³⁷ For example, *In re Conroy* 486 A. 2d 1209 (1985); *In re Farrel* 529 A. 2d 404 (1987).

²³⁸ Oddi, 634.

²³⁹ In any event, the courts have held on a number of occasions, that a doctor who withholds or withdraws treatment at the request of a competent patient or in respect of an incompetent patient in the patient's 'best interests' will not incur civil or criminal liability; e.g. *In re Quinlan* 355 A. 2d 647 (1976) (see discussion below, 73-74).

²⁴⁰ *In re Quinlan* 355 A. 2d 647 (1976).

²⁴¹ See above, 52-53.

²⁴² See also *In re President & Directors of Georgetown College, Inc.* 331 F. 2d 1000 (1964); *John F. Kennedy Memorial Hospital v Heston* 58 N.J. 576 (1971).

²⁴³ 355 A. 2d 647, 663, 667 (1976).

²⁴⁴ *Id.* 665.

deeming itself bound or controlled thereby.²⁴⁵ The court held that in the circumstances, the State interest in defending the right of the doctor was not sufficiently compelling to override the patient's right to privacy.

In subsequent cases, the courts have more clearly articulated the relevant State interest in preserving the ethical integrity of the medical profession and the manner in which it can be reconciled with the right of an individual to refuse treatment.²⁴⁶ In *Superintendent of Belchertown v Saikewicz*²⁴⁷ referred to above,²⁴⁸ there was recognition from the court that:

Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather...the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores: such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same.²⁴⁹

A similar approach was espoused by the Supreme Court of New Jersey in the case of *In re Conroy*, considered earlier,²⁵⁰ in the context of the issue of withdrawal of artificial nutrition and hydration.²⁵¹ In dismissing the State's interest in maintaining the ethical integrity of the medical profession in this case, the court reiterated that medical ethics do not require medical intervention at all cost, and reference was made to surveys indicating that a majority of doctors now practice passive euthanasia. As the court observed, even if doctors were exhorted to attempt to cure or sustain their patients under all circumstances, that moral and professional imperative, at least in cases of patients who are clearly competent, would not go beyond advising the patient of the risks of forgoing treatment and urging the patient to accept the medical intervention. The court concluded:

Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.

Thus the approach of the courts, as exemplified in these cases, is to give the patient's right of self-determination priority over the State interest in the integrity of the medical profession. In most cases, the withholding or withdrawing of treatment will be consistent with prevailing medical ethics and practices, and even in rare circumstances where the treating doctors are ethically opposed to the

²⁴⁵ *Id.* 666, 669. But see Horan, 528-9 where the author is critical of the court's dismissal of accepted medical standards.

²⁴⁶ For example, *Superintendent of Belchertown v Saikewicz* 370 N.E. 2d 417 (1977); *In re Conroy* 486 A. 2d 1209 (1985); *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986); *Bartling v Superior Court* 163 Cal. App. 3d 186 (1984); *Satz v Perlmutter* 362 So. 2d 160 (1978).

²⁴⁷ 370 N.E. 2d 417 (1977).

²⁴⁸ See above, 53.

²⁴⁹ *Id.* 426-427.

²⁵⁰ See above, 55-56, 63.

²⁵¹ 486 A. 2d 1209 (1985). Although the American Medical Association has endorsed the removal of artificial nutrition and hydration in appropriate cases, (see above, n. 212) this area has been the subject of intense debate and many doctors are opposed to the withdrawal of these forms of medical care.

withdrawal of treatment, the court is nevertheless likely to give effect to the patient's request.²⁵² Furthermore, even though a patient has refused life-saving treatment, the health care professionals are under an obligation to continue to provide palliative care to the patient, notwithstanding that they may disapprove of the patient's decision.²⁵³

The courts in the United States have adopted the correct approach in subordinating the State interest in safeguarding the ethical integrity of the medical profession to the patient's right of self-determination. Neither prevailing ethical standards in the medical profession, nor the professional judgment of an individual doctor should be allowed to override the decision of a patient to reject treatment. The alternative would be to eliminate consent altogether and to absolutise the standard of good medical practice.²⁵⁴ If a doctor has a genuine conscientious objection to the patient's refusal of treatment the most appropriate solution is to allow the doctor to withdraw from the management of that patient, rather than to compel the patient to accept unwanted medical treatment.²⁵⁵

The Australian Position: Applicability of the American Experience?

The foregoing discussion has focussed on the legal position in the United States, since the question of the patient's right to refuse treatment has been most fully litigated and analysed in that country. In comparison with developments in the United States, the law in Australia and England with respect to the right of a patient to refuse treatment is still in its formative stages.²⁵⁶ As was seen in the earlier analysis, apart from reliance upon ancient common law concepts regarding non-consensual touching, there is little direct authority in support of the patient's right to refuse treatment.²⁵⁷ In view of the dearth of relevant case law in these jurisdictions and the wealth of American authority, it is quite possible that the American cases which have strongly defended the right of a competent patient to refuse treatment may be influential in the future in shaping Australian and English law in this area. It is difficult to predict whether the courts in Australia are likely to follow the details of the American approach, balancing the individual's right to refuse treatment against competing State interests.²⁵⁸ To

²⁵² It is interesting in this context to note the case of *Brophy v New England Sinai Hosp. Inc.* 497 N.E. 2d 626 (1986) in which the treating doctors were opposed to the withdrawal of artificial nutrition and hydration from a patient in a persistent vegetative state. Notwithstanding that this view was inconsistent with a substantial body of medical opinion, the court sought to avoid making an order which would compel the treating doctors to withdraw treatment against their own judgment and accordingly made an order that the hospital assist in the transfer of the patient to another institution where the wishes of the patient could be given effect to. This decision has, however, been subject to criticism; see Annas, 'Transferring the Ethical Hot Potato' 21. On this subject of the doctor's and hospital's role, note also *Gray v Romeo* 697 F. Supp. 580 (1988), decision of the Federal District Court of Rhode Island, discussed by I. Loftus, 'I Have a Conscience, Too: The Plight of Medical Personnel Confronting the Right to Die' (1989) 65 *Notre Dame L.Rev.* 699.

²⁵³ For example, *Bouvia v Superior Court* 225 Cal. Rptr. 297, 306 (1986).

²⁵⁴ Grisez and Boyle, 96.

²⁵⁵ *Ibid.*

²⁵⁶ Whilst the same applies for New Zealand, the position in Canada is significantly more advanced, see, for example, *Malette v Shulman* (1991) 2 Med.L.R. 162; *Nancy B. v Hotel-Dieu de Quebec et al* 69 C.C.C. (3d) (1992) 450.

²⁵⁷ See above, 33.

²⁵⁸ It must be emphasised that the courts in the United States have held that patient's right to refuse treatment must be balanced against State interests regardless of whether that right is based on the

some extent, the rudimentary elements of this approach already exist; for example, with regard to the State's interest in the preservation of life, the common law has always upheld life as sacred and has consequently sought to prevent persons from permitting their own destruction. It has also been frequently assumed that the right to refuse treatment may be curtailed in circumstances where the exercise of that right may cause danger to the life or health of others.²⁵⁹ Even if this balancing approach is adopted, in the final analysis, the courts would be inclined to uphold and protect the patient's right to refuse treatment. The general principles of self-determination and bodily integrity are already well recognised at common law and can readily be applied in the medical context so as to empower patient's to make their own treatment decisions, even in circumstances where the patient's life is at stake.²⁶⁰

Significantly, one of the few English cases to directly consider the patient's right to refuse treatment has adopted this approach and is a good indication of the way in which the Australian courts are likely to proceed. In the recent Court of Appeal decision in *Re T*²⁶¹ Lord Donaldson M.R. recognised that a refusal of treatment situation, particularly where life-saving treatment is at issue, gives rise to a conflict between the interests of the patient and that of the society in which the patient lives:

The patient's interest consists of his right to self-determination - his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. *It is well established that in the ultimate the right of the individual is paramount.*²⁶²

As a matter of principle, the only justification for interference with the patient's right to refuse treatment is if the exercise of that right in some way endangers other persons.²⁶³ Where the patient's refusal of treatment does not pose a risk of harm to others, and provided that the patient has decision-making capacity, the patient's decision ought to be respected, regardless of whether in the opinion of the patient's medical advisers the decision may appear foolish or unreasonable.²⁶⁴

common law or the Constitution. (see above, 48 and n. 113.) Analysis of State interests in the United States is therefore not simply a constitutional requirement.

²⁵⁹ See, for example, the Victorian Social Development Committee Report, 98 where it is suggested that an exception to the right to refuse medical treatment may occur when the public interest is adversely affected; for example, if a criminal offence will be committed, or an innocent third party, or the public generally will suffer if the right is upheld. This is the approach adopted by the courts in Canada. In *Nancy B. v Hotel-Dieu de Quebec et al* 69 C.C.C. (3d) (1992) 450, 456 it was held by the Quebec Superior Court that the right of an individual to refuse treatment is almost absolute, being subject only to a corresponding right of others to maintain their life and health.

²⁶⁰ This would include the decision to refuse all forms of treatment, even nutrition and hydration. Whilst there have been no Australian or English authorities involving the refusal of nutrition and hydration by a competent patient, there has been a recent High Court ruling in the United Kingdom in which the court authorised the withdrawal of a naso-gastric tube from a 22 year old patient, Tony Bland, who was in a persistent vegetative state. At the time of writing, an appeal to the English Court of Appeal was pending.

²⁶¹ Court of Appeal Transcript, July 30 1992.

²⁶² Author's emphasis. His Lordship did, however, say that the strong public interest in the preservation of life calls for a careful examination of the circumstances in which an individual is exercising that right and 'in cases of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms.'

²⁶³ For example, in circumstances where a patient purports to refuse medical treatment in respect of a serious contagious disease. See also C. Heifetz with M. Mangel, *The Right to Die* (1975) 27-29. The situation regarding possible harm to unborn children requires special consideration; see above, 44.

²⁶⁴ *Smith v Auckland Hospital Board* [1965] N.Z.L.R. 191, 219 and see above, 42.

Once it is accepted that a patient has a legal right to refuse treatment, it follows that that right is legally enforceable. Thus, in the event of breach, the patient can bring an action by way of civil damages²⁶⁵ or even criminal prosecution for assault. Alternatively, in anticipation of a breach or continuing contravention, legal proceedings can be instituted for injunctive relief, restraining the medical practitioner from performing any procedure or administering treatment without the consent of the patient.²⁶⁶ Accordingly, doctors are under a legal duty to respect the directions of a patient who has decision-making capacity.²⁶⁷ In addition to the patient's remedies in tort and criminal law, a patient may discharge him or herself from the care of the medical practitioner and seek out a medical practitioner who will respect his or her wishes.²⁶⁸

PART II

Legal Effect of Patients' Right to Refuse Treatment Upon Doctors' Duty to Treat

Introduction

Having established that a patient has a legally enforceable right at common law to refuse treatment it now becomes necessary to consider the legal effect of a patient's refusal of treatment upon a doctor's duty towards his patient under the criminal law. In the preceding chapter, it was seen that a doctor may be criminally liable for an omission to treat in circumstances where he or she was under a legal duty to provide treatment.²⁶⁹ It is therefore necessary to examine whether, in circumstances where a doctor is under a *prima facie* duty to treat, a direction by a patient who has decision-making capacity, that treatment be withheld or discontinued effectively extinguishes the doctor's duty to treat so as to absolve the doctor from criminal liability in the event that the patient's death is caused or hastened by the omission of treatment. Consideration will first be given to those jurisdictions where the criminal law is dealt with under common law principles.

The Position at Common Law

One is immediately confronted with a fundamental and apparently irreconcilable inconsistency between the criminal law principles in relation to the validity of consent on the one hand, and common law

²⁶⁵ J. Hasl, 'Patient Autonomy and the Right to Refuse Treatment: Available Remedies' (1989) 33 *St. Louis U.L.J.* 711.

²⁶⁶ *Ibid.* See also the Victorian Social Development Committee Report, 274.

²⁶⁷ See Oddi, 636 where he discusses 'rights' and correlative 'duties'.

²⁶⁸ Baugham, Bruha and Gould, 1208; P. Foreman, 'The Physician's Criminal Liability for the Practice of Euthanasia' (1975) 27 *Baylor L.Rev.* 54, 60. See also the Victorian Social Development Committee Report, 98-99 where the committee referred to advice which was received by the committee to this effect. However, the committee was strongly of the view that this analysis is divorced from the realities of a person *in extremis* and rejected this argument as 'cynical and unrealistic'.

²⁶⁹ See chapter I, 19-30.

principles regarding patient self-determination on the other. It is well established that the consent of the victim is no defence to the crime of murder. Even where it can be shown that the consent of the victim went beyond mere acquiescence and involved a firm request that the defendant bring about the victim's death, it would nevertheless be irrelevant for the purposes of the criminal law. Thus, at first glance, it might appear that a doctor who complies with a patient's refusal of treatment, where that is likely to result in the death of the patient, could be liable for homicide and the consent of the patient would not be a valid defence. This would seem to be a rather perplexing result which could potentially undermine the right of a patient to refuse treatment. Apart from a number of American decisions and a recent Canadian case,²⁷⁰ there is no common law authority directly dealing with this issue and whilst there is a mass of academic literature on the subject of a patient's right to refuse treatment, this particular question has been largely neglected. Most commentators have simply assumed that a doctor can lawfully comply with a patient's refusal of treatment whilst others have cast doubt on the effectiveness of consent in these circumstances.²⁷¹ The failure to adequately address this issue has, in turn, resulted in uncertainty for the medical profession, with doubts frequently expressed by many doctors about their potential liability if they withhold or withdraw treatment at the patient's request, and the patient's death results.²⁷² Given the importance of this issue, it is essential that the legal position be clarified and that doctors and patients are made aware of their legal rights and responsibilities.

Notwithstanding the criminal law rules regarding the irrelevance of consent to a charge of homicide, the wishes and directions of a patient, who has decision-making capacity, are in fact critical and will, in certain circumstances, exculpate a doctor from criminal liability. From the outset it is vital to identify exactly what the criminal law prohibits. A person cannot give a valid consent to the taking of life where that constitutes a criminal offence. Clearly, therefore, a patient cannot give a valid consent to a doctor to take active steps to take his or her life since that would amount to the criminal offence of murder. But, as we have seen, the basis of a doctor's liability for omissions to treat is predicated upon the existence of a legal duty in respect of that patient. If, as a result of the patient's refusal of treatment, there is no duty to treat, failure to provide that treatment cannot amount to a culpable omission for the purposes of the criminal law. On this reasoning, the patient's refusal of treatment would not amount to consent to a criminal offence. Consequently, the criminal law rules which hold consent irrelevant as a defence to criminal conduct, would have no application.

²⁷⁰ Discussed below, 78-79.

²⁷¹ See, for example, the opinion of the New South Wales Crown Solicitor, in a letter of advice regarding the legal ramifications for hospitals and others who withhold potentially life-saving treatment from seriously ill patients. (A copy of this letter is included in the Appendix of the New South Wales Health Department, Discussion Paper, *Proposed Legislation to Give Legal Effect to Directions Against Artificial Prolongation of the Dying Process* (1990)). For discussion of the criminal law principles with regard to consent, see chapter I, 16-18.)

²⁷² See above, 32.

An initial objection may be raised that since the doctor's duty to treat is imposed by law, for the benefit not only of the individual, but also for the benefit of the State,²⁷³ the absolution by the patient is ineffective in relieving the doctor of his duty.²⁷⁴ In response it can be asserted that although the doctor's duty to treat is imposed by law, the individual's right of self-determination must ultimately prevail and override any interest the State may have in the preservation of the individual's life.

In order to substantiate the foregoing argument, it is necessary to examine in more detail the nature of the doctor/patient relationship and the circumstances in which a patient can effectively limit or terminate a doctor's duty to provide treatment.

Whilst under normal circumstances, a doctor is under a duty to provide treatment to his or her patient, the doctor's duty may be limited or terminated by a patient, who has decision-making capacity, refusing treatment. Alternatively, the doctor's legal duty may be terminated by the patient formally discharging his or her doctor.

In the foregoing part it was argued that under common law principles and subject only to a few limited exceptions,²⁷⁵ all patients who have decision-making capacity have the right to refuse treatment, even life-saving treatment and any treatment administered contrary to a patient's expressed wish is unlawful and may attract both civil and criminal liability. Since a patient has a legally enforceable right to refuse treatment it should logically follow that a doctor who complies with the instructions of a patient, who has decision-making capacity, that treatment be withheld or withdrawn would not be acting in violation of the criminal law.²⁷⁶ The law gives the doctor no authority to act against the patient's wishes so the failure to do so cannot amount to breach of any duty by the doctor.²⁷⁷ It is also possible that the patient terminates the doctor/patient relationship which gives rise to the doctor's duty to treat. If a patient does terminate the relationship in this way, the doctor's legal duty to the patient would come to an end and the doctor would incur no liability for the consequences of any omission to provide further treatment.²⁷⁸

²⁷³ This reasoning is consistent with other aspects of the criminal law which have upheld the sanctity of life; see, for example, chapter I, 17-18 for a discussion explaining the rationale behind the prohibition on a person being able to give a legally effective consent to death.

²⁷⁴ See Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors,' 229-230 where this question is raised.

²⁷⁵ See above, 40-45.

²⁷⁶ I. Kennedy, 'Switching Off Life Support Machines: the Legal Implications' (1977) *Crim.L.Rev.* 443, 450; Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors,' 229-230; Williams, *Textbook of Criminal Law*, 279. There are, however, practical problems involved in determining whether the patient has the capacity to make such a decision, with the resulting risk of liability if it subsequently found that the patient lacked the necessary capacity to refuse treatment; E. Gurney, 'Is there a Right to Die? - A Study of the Law of Euthanasia' (1972) 3 *Cumberland-Samford L.Rev.* 235, 244.

²⁷⁷ Williams, *Textbook of Criminal Law*, 279 n. 1 to the effect that the D.P.P. will not in such circumstances institute a prosecution; see the A.G.'s statement in Note, (1982) 284 *B.M.J.* 1562.

²⁷⁸ Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors,' 229; D. Meyers, *Medico Legal Implications of Death and Dying* (1981) 140; Baugham, Bruha and Gould, 1208; Foreman, 60.

Thus, by refusing treatment and/or terminating the doctor/patient relationship, the patient in effect absolves the doctor of his or her legal duty to act. Any interest the State may have in the imposition of that duty is outweighed by the patient's right of self-determination. In the absence of a duty to act no criminal liability can result from the doctor's omission to provide treatment.²⁷⁹ Indeed, if it were otherwise, a doctor would be compelled by the law to act unlawfully, by providing unauthorised medical treatment in order to avoid liability for the more serious offence of murder. In response it could be argued that a doctor in these circumstances could possibly plead the defence of necessity as a defence to an action for criminal assault.²⁸⁰ Acceptance of this argument would, however, entail inappropriately subordinating the individual's right of self-determination to the principle of preservation of life.²⁸¹

The Case Law

There have been no decided cases in Australia or the United Kingdom directly dealing with the scope of a doctor's duty for the purposes of the criminal law, in circumstances where a patient, with decision-making capacity, has refused life-saving medical treatment.²⁸² In fact, the only jurisdiction under consideration where these issues have been addressed is the United States, so attention will be focussed on the case law in that country.

Although the refusal of treatment cases which have been decided in the United States have largely occurred independently of the criminal law, they nevertheless have significant implications for criminal law principles. In upholding patient autonomy and self-determination as the determinative factors in the medical context, the courts in the United States have held, either expressly or by implication, that it would not be unlawful for a doctor to act upon a patient's request that treatment be discontinued.

One of the earliest cases to consider the criminal liability of a doctor for the withdrawal of treatment from a patient was *In re Quinlan*,²⁸³ although the case did not actually involve criminal proceedings.²⁸⁴ In that case, the facts of which have been outlined above,²⁸⁵ the New Jersey

²⁷⁹ V. Thurman, 'Euthanasia: The Physician's Liability' (1976-7) 10 *John Marshall Jr.* 148, 152.

²⁸⁰ For Australian authority in support of the existence of a general defence of necessity in the criminal law see *R v Loughnan* [1981] V.R. 443. Note also the Canadian case *Perka v R* (1985) 14 C.C.C. 3d 385, 417-420 which specifically recognises the existence of the defence of necessity in circumstances where the defendant is faced with conflicting legal duties. With the exception of Tasmania, the Code jurisdictions contain a statutory version of the defence of necessity; see N.T. s. 33; Qld. s. 25; W.A. s. 25.

²⁸¹ Lanham, 'The Right to Choose to Die with Dignity,' 406-407.

²⁸² This is also the position in Canada and New Zealand.

²⁸³ 355 A. 2d 647 (1976).

²⁸⁴ For a criminal case arising outside the medical context, see *People v Robbins* 443 N.Y.S. 2d 1016 (1981). In this case a patient suffering from epilepsy and diabetes decided to stop taking all her medication on the basis of religious conviction. The court accepted that a husband had a legal duty to summon care or to administer insulin to his wife when she became incapacitated, but that there would be no breach of that duty if the wife, while capable of doing so, had made a rational decision to forgo medical assistance. It was accepted by the New York Court of Appeal, that since treatment could not be administered against her wishes, the State could not impose criminal sanctions on her husband for respecting the wishes of his wife.

²⁸⁵ See above, 52.

Supreme Court held that, on the assumption that the removal of the respirator from the patient could be classified as homicide, the death would not come within the scope of unlawful killings proscribed by statute. The court concluded that the termination of treatment pursuant to the constitutional right of privacy is *ipso facto* lawful and that the constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right.²⁸⁶ Accordingly, doctors participating in the removal of the respirator would be protected from criminal liability. Although the reasoning of this case is obviously founded on the constitutional right of privacy (which has, implicitly at least, been rejected by the United States Supreme Court as encompassing the right of a patient to refuse treatment²⁸⁷) the case can be interpreted as authority for the wider proposition that where a patient has a right to refuse treatment, whether based upon constitutional principles or the common law, doctors may lawfully comply with the patient's directions, without fear of criminal prosecution. Implicit in this conclusion is the proposition that in circumstances where a competent patient has refused treatment, a doctor is no longer under a legal duty to provide that treatment.

The criminal law issues were more clearly spelt out in the *Barber* case²⁸⁸ (noted above²⁸⁹) where the treating doctors actually faced criminal prosecution for murder. The Californian Court of Appeal held that the doctor's omission to continue life-support treatment for a terminally ill and comatosed patient, though intentional and in the knowledge that the patient would die, was not an unlawful failure to perform a legal duty.²⁹⁰ Although this case actually involved an incompetent patient, the court made it clear that in determining whether a doctor is under a duty to provide medical treatment of debateable value, the patient, whenever possible, should be the ultimate decision-maker.²⁹¹

On the basis of these cases, and others decided along similar lines,²⁹² the position in the United States would appear to be that a doctor can withhold or withdraw treatment at the request of a competent patient without incurring criminal liability, even though the patient's death may result. These cases, particularly the *Barber* case specifically dealing with the question of criminal liability, support the proposition that the refusal of treatment by a competent patient effectively terminates the doctor's duty to provide treatment, in such a manner that the subsequent omission of treatment is not a culpable omission for the purposes of the criminal law.

Since consent is part of the general theory of law, it is both logical and desirable that its effects should be the same in all branches of law.²⁹³ Under private law principles, the courts have recognised the right of an individual to either give or refuse consent to treatment, and there are strong arguments in favour of the common law rights being given parallel effect under the criminal law. The principal

²⁸⁶ 355 A. 2d 647, 670 (1976).

²⁸⁷ See above, 47-48, 59-60.

²⁸⁸ *Barber v Superior Court* 195 Cal. Rptr. 484 (1983).

²⁸⁹ See above, 62-63.

²⁹⁰ *Id.* 493.

²⁹¹ *Id.* 492.

²⁹² For example, *In re Farrel* 529 A. 2d 404, 415-416 (1987).

²⁹³ Castel, 318.

advantage to be derived from the development of a unified doctrine is the guarantee of consistency and uniformity in the application of legal principle. Indeed, if it were otherwise, doctors would be faced with a most unsatisfactory dilemma; they would, on the one hand, be required to comply with the patient's legally enforceable right to decline treatment, yet, if no regard was given to the fact of patient consent and the patient's right to refuse treatment, the doctor could be criminally liable if the patient died as a result of his failure to provide treatment. As doctors are legally bound to respect the wishes of a patient who has decision-making capacity, they should not thereby be at risk of criminal liability.²⁹⁴ If the right to refuse treatment is to have any real meaning, it must be given parallel effect in the criminal law so that the refusal of treatment by a patient who has decision-making capacity, terminates the doctor's obligation to treat, and thereby absolves the doctor of any liability.²⁹⁵

The Position Under the Australian Criminal Codes

Each of the Australian Criminal Codes contains a specific provision to the effect that the victim's consent to death does not affect the question of criminal liability.²⁹⁶ Questions therefore arise also in Code jurisdictions regarding the legal effect of a patient's refusal of treatment upon the doctor's criminal liability.

A preliminary matter meriting investigation is the wording of the provisions invalidating consent contained in the Codes of Tasmania and the Northern Territory. The relevant sections respectively provide that a person cannot consent to '*the infliction of death upon himself*' or '*permit another to kill him*.'²⁹⁷ As a matter of interpretation, it could be argued that the phrases 'infliction of death' and 'kill' imply some *active* intervention rather than an *omission* to act and therefore have no application in relation to the withholding or withdrawing of treatment which results in death. If these provision are held not to apply in this context, there would appear to be nothing in the Tasmanian or Northern Territory Codes to prevent a doctor from relying upon the consent of the deceased as a defence to any charges arising from the death of the patient. The relevant provision in the other Code jurisdictions

²⁹⁴ Grisez and Boyle, 101.

²⁹⁵ Law Reform Commission of Canada, Working Paper No. 26, *Medical Treatment and the Criminal Law* (1980) 73.

²⁹⁶ Section 53 of Tasmanian *Criminal Code* 1924 provides that 'No person has a right to consent to the infliction of death upon himself and any consent given in contravention hereof shall have no effect as regards criminal responsibility.' The relevant provision in the Queensland and Western Australia Criminal Codes states 'consent by a person to the causing of his own death does not affect the criminal liability of any person by whom such death is caused.' (s. 284 and s. 261 respectively.) Section 26(3) of the Northern Territory *Criminal Code* 1983 provides that 'A person cannot authorise or permit another to kill him or, except in the case of medical treatment, to cause him grievous harm.' Note also s. 14 of the Canadian *Criminal Code* 1985; s. 63 of the New Zealand *Crimes Act* 1961.

Whilst it could be argued that a clear direction from a patient that his or her death be brought about is not equivalent to mere 'consent', it is likely that the term 'consent' under the Codes would, as at common law, be interpreted to include active requests for death.

²⁹⁷ N.T. s. 26(3); Tas. s. 53. (Author's emphasis.)

provides that a person cannot consent to the *causing of his own death* and is therefore, not open to the same interpretation.²⁹⁸

Leaving aside this statutory interpretation argument, it is still open to assert that notwithstanding the terms of the various Code provisions regarding the irrelevance of consent to death, a doctor can lawfully comply with a patient's request that no further treatment be administered, even though the patient's death will result. The reasoning which lies behind this conclusion parallels that set out above with respect to those jurisdictions where the criminal law is dealt with at common law;²⁹⁹ the refusal of treatment by a patient effectively terminates the doctor's duty to provide treatment.³⁰⁰ In the absence of a duty to provide treatment, the doctor's omission to provide that treatment is not a culpable omission for the purposes of criminal liability under the Codes and no liability can arise. On this reasoning, the provisions invalidating consent are irrelevant, since they only apply where criminal liability is established.³⁰¹ In order to substantiate this argument, consideration must be given to the rights a patient has to refuse treatment in Code jurisdictions, and the effect these rights have on the duty of a doctor to provide treatment.

The common law principles regarding civil liability for non-consensual touching which underlie the individual's right of self-determination, apply with equal force in the Code jurisdictions.³⁰² In addition to the rights a patient has at common law, there are a number of provisions in the Codes which seek to protect individuals against any invasion of their bodily integrity. Apart from those circumstances where consent is specified to be irrelevant,³⁰³ the Code provisions regarding crimes against the person generally uphold the right of an individual to authorise or alternatively refuse bodily contact.³⁰⁴ Thus, it could be argued that the Criminal Codes in Australia have preserved the basic common law approach which upholds the right of an individual to refuse intrusion on his or her body, except where there is a specific statutory exception providing otherwise.³⁰⁵ If the common law right to refuse unwanted bodily contact is indeed consistent with the approach of the Codes, it

²⁹⁸ Qld. s. 284; W.A. s. 261. (Author's emphasis.)

²⁹⁹ See above, 74-75.

³⁰⁰ *Contra* P. Gerber and A. Vasta, 'Criminal Law' (1984) 58 *A.L.J.* 291; P. Gerber, 'Brain Death, Murder and the Law' (1984) 140 *M.J.A.* 536 where it is argued that by virtue of the Code provision regarding consent, a direction by a patient to discontinue treatment would not absolve a doctor from criminal responsibility in the event that the omission causes the death of the patient.

³⁰¹ With the exception of the Northern Territory (s. 26(3)) the relevant Code provisions are in terms that consent to death has no effect with regard to criminal responsibility. (Qld. s. 284; Tas. s. 53; W.A. s. 261. Note also s. 14 of the Canadian *Criminal Code* 1985; s. 63 of the New Zealand *Crimes Act* 1961.) In the definition section of all the Australian Codes, 'criminal responsibility' is defined as meaning liability to punishment as for an offence; e.g. Qld. s. 1.

³⁰² In the Northern Territory certain statutory rights also exist under the *Natural Death Act* 1988 (For further discussion, see Chap VII, 310-311.). Note also Article 19.1 of the *Civil Code of Lower Canada* inserted in 1989.

³⁰³ See above, n. 296.

³⁰⁴ For example, provisions in relation to rape (e.g. Tas. s. 185) and the offence of assault (e.g. Tas. s. 182(4)).

³⁰⁵ See also Law Reform Commission of Canada, *Medical Treatment and Criminal Law*, 71 where this point is made with reference to the provisions of the Canadian *Criminal Code* 1985.

logically follows that it may be relevant in determining the scope of the doctor's duty to treat for the purposes of the criminal law in Code jurisdictions.³⁰⁶

As indicated in the preceding chapter,³⁰⁷ in Code jurisdictions, the duty of a doctor to provide treatment arises as a result of the combined effect of the duty provisions in the Codes relating to the preservation of human life and the provisions relating to unlawful killing. In circumstances where a doctor is under a duty to provide treatment to a patient, he or she will be held criminally responsible for any consequences which result from his or her omission to act.³⁰⁸ In determining the effect of a patient's refusal of treatment upon the scope of the doctor's duties under the Codes, it is necessary to have regard to the two duty provisions which are of particular relevance to the question of the liability of doctors for withholding or withdrawing of treatment; the duty to provide necessities,³⁰⁹ and the duty to do acts undertaken, the omission of which would be dangerous to human life or health.³¹⁰

Duty to Provide Necessaries of Life

Before a duty to provide the necessities of life can arise, a person must have 'charge of another, who is unable by reason of age, sickness, unsoundness of mind, detention or any other cause to withdraw himself from such charge....'³¹¹ It is clear from the terms of the Code provisions that the charge can arise in a number of ways, including under contract, by imposition of law or by voluntary undertaking.³¹² Whether a person has charge of another is a question of fact in each case.³¹³ Under normal circumstances, a doctor clearly has charge of a sick patient, and the doctor would therefore be under a duty to provide the patient with the 'necessaries of life.'³¹⁴ The crucial question for the purposes of the present inquiry is the effect that a patient's refusal of treatment has upon this concept of charge and, in particular, whether the patient thereby 'withdraws himself from the charge' within the meaning of the section. On the basis of the wording of the provision, it is certainly open to argue that in the medical context, a patient who has decision-making capacity, is free to withdraw him or herself from the charge by requesting that treatment be withdrawn or withheld, and this would effectively terminate any duty of the doctor to provide further treatment.³¹⁵ If the patient subsequently died as a

³⁰⁶ See, however, the contrary view of Gerber and Vasta, 295 regarding the Queensland provision, where they suggest that a directive of a patient to cease treatment would not absolve a doctor from liability if any omission caused the patient's death. In their view, the only way in which a doctor could be absolved from liability is by reading down the requirement with regard to the 'necessaries of life'.

³⁰⁷ Chapter I, 22-25.

³⁰⁸ N.T. s. 153; Qld. ss. 285-290; Tas. s. 152; W.A. ss. 262-267.

³⁰⁹ N.T. s. 149; Qld. s. 285; Tas. s. 144; W.A. s. 262. Note also s. 215 of the Canadian *Criminal Code* 1985; s. 151 of the New Zealand *Crimes Act* 1961.

³¹⁰ N.T. s. 152; Qld. s. 290; Tas. ss. 151-152; W.A. s. 267. Note also s. 217 of the Canadian *Criminal Code* 1985; s. 157 of the New Zealand *Crimes Act* 1961.

³¹¹ N.T. s. 149; Qld. s. 285; Tas. s. 144; W.A. s. 262. Note also s. 215(1)(c) of the Canadian *Criminal Code* 1985; s. 151 of the New Zealand *Crimes Act* 1961.

³¹² N.T. s. 149; Qld. s. 285; Tas. s. 144(2); W.A. s. 262. Note also s. 151 of the New Zealand *Crimes Act* 1961.

³¹³ *R v McDonald* [1904] Qld. S.R. 151; *R v McCallum* [1969] Tas. S.R. 73, 78.

³¹⁴ Under the Tasmanian *Criminal Code* 1924, 'necessaries of life' are stated to include 'medical and surgical aid' and 'medicine'; see s. 146. There is no definition of this term in the other Code jurisdictions, but it is clear from judicial interpretation of this phrase, both under the Codes and at common law, that it includes medical treatment. (See chapter I, 23-24.)

³¹⁵ There are a number of early English cases which examine in a non-medical context, whether the deceased was able to withdraw him or herself from the control or charge of the defendant; *R v Smith*

result of the omission to treat, the doctor would not be criminally responsible, since he or she was no longer under a duty to provide treatment. This interpretation of the provision is in accordance with common law principles outlined above,³¹⁶ and would therefore have the advantage of a uniform approach as between Code and common law jurisdictions.

Duty to Do Acts Undertaken

In addition to the duty to provide necessities, a doctor may also be under a duty to do 'an act undertaken, the omission of which may be dangerous to human life or health'.³¹⁷ A doctor may have undertaken to provide treatment to a patient by entering into a doctor/patient relationship. Once treatment has been undertaken, any cessation of that treatment which may be dangerous to the life or health of the patient comes directly under this provision. It remains to be considered what effect the patient's refusal of treatment has upon the doctor's duty to do acts undertaken. It is clear that the undertaking may, in certain circumstances, be terminated; by mutual consent, revocation by the patient, or lack of need for medical services. It logically follows that the refusal of treatment by a patient terminates the doctor/patient relationship, thereby bringing to an end any duties the doctor may have in respect of the patient, including the duty to do acts undertaken.³¹⁸ Consequently, any omission to perform that duty which results in the death of the patient is not a culpable omission for the purposes of the criminal law.

The only case to specifically consider the criminal liability of a doctor for the withholding or withdrawing of medical treatment in a Code jurisdiction is the Canadian case of *Nancy B. v Hotel-Dieu de Quebec et al.*³¹⁹ This case involved a competent 25 year old patient who was suffering from an incurable neurological disorder that left her incapable of movement. She had refused further treatment including the respirator upon which she was dependent. She sought an injunction against her doctor and the hospital to require them to comply with her decision. Although a case arising in the civil jurisdiction, the Quebec Superior Court also examined the criminal law implications of a doctor's compliance with a patient's request that artificial respiratory support be removed. The principal section of the Canadian *Criminal Code* 1985 considered by the court was s. 217 dealing with the duty of persons undertaking acts, the omission of which may be dangerous to life. The court recognised that if strictly interpreted, this provision would have the effect that a doctor who has undertaken treatment is not permitted to terminate that treatment if that involves a risk of life to the patient.³²⁰ The court was, however, anxious to avoid this result and held that the section must be

(1865) 169 E.R. 1533; *R v Chattaway* (1922) 17 Cr. App. R. 7. These cases lend some support to the view that a patient could withdraw from a doctor's charge by requesting that treatment be withdrawn or withheld.

³¹⁶ See above, 71-75.

³¹⁷ N.T. s. 152; Qld. s. 290; Tas. ss. 151-152; W.A. s. 267. Note also s. 217 of the Canadian *Criminal Code* 1985; s. 157 of the New Zealand *Crimes Act* 1961.

³¹⁸ Note, however, academic opinion to the contrary; see Law Reform Commission of Canada, *Medical Treatment and the Criminal Law*, 27 where a number of commentators are cited who are of the view that the refusal of treatment by a patient does not necessarily constitute revocation of the doctor/patient contract and does not justify abandonment by the doctor.

³¹⁹ 69 C.C.C. (3d) (1992) 450.

³²⁰ *Id.* 458.

read in context with other provisions in the Code which exclude from criminal liability conduct which can be characterised as 'reasonable'.³²¹ The court concluded that the conduct of a doctor who stops respiratory support treatment of his or her patient at the freely given and informed request of the patient, so that nature may take its course, could not be characterised as unreasonable. Adopting a broad and liberal interpretation of the Code, the court accordingly held that persons involved in terminating the patient's respiratory support treatment in order to allow nature to take its course would not commit any crime under the Code. The court emphasised that unlike cases of homicide and suicide which are not natural deaths, if the patient's death takes place after the respiratory support treatment is stopped at the patient's request it would be the result of nature taking its course.³²²

In reaching this conclusion, the court did not specifically consider the effect of s. 14 of the Canadian *Criminal Code* 1985 which invalidates a victim's consent to his or her own death. Implicit, however, in the court's reasoning is the view that in circumstances where a patient has freely and informedly refused treatment the doctor is no longer under a legal duty to provide that treatment. This decision, based upon a Code in similar terms to the Australian Criminal Codes, provides support for the proposition that a doctor who withholds or withdraws treatment at the direction of the patient will not incur criminal liability.

Lawful Excuse

In the foregoing paragraphs it has been argued that the refusal of treatment by a patient in effect extinguishes the doctor's duty to treat, thereby absolving the doctor from any criminal liability arising from his or her omission to provide treatment. In Code jurisdictions, an alternative argument can be based upon the notion of lawful excuse.

For the purposes of the Tasmanian Code, even if the courts were to hold that the refusal of treatment by a patient does not affect the doctor's duties under the Codes, it would still be possible to argue that a doctor who, at the request of the patient, omits to provide treatment, has lawful excuse. Section 152 is a general provision dealing with criminal responsibility for omissions. Under that section, the absence of lawful excuse is a prerequisite for criminal liability.³²³ It could therefore be argued that the patient's request that treatment be terminated in exercise of the patient's common law right to refuse treatment, provides lawful excuse for the doctor to act on that request and withhold or withdraw treatment.³²⁴ Since the doctor is bound by law to respect the wishes of the patient, it must be possible for the doctor to comply with the patient's request without incurring criminal liability.

³²¹ *Id.* 458-459, referring to ss. 216, 45 and 219(1) Canadian *Criminal Code* 1985.

³²² *Id.* 460.

³²³ Section 152; 'A person who without lawful excuse omits to perform any of the duties mentioned in this chapter shall be criminally responsible for such omission.'

³²⁴ See also the Law Reform Commission of Canada, *Medical Treatment and the Criminal Law*, 23 where it is noted that the wilful choice of the person to whom the duty to provide necessities is owed, not to receive them, constitutes lawful excuse. Some support for this view can also be derived from the case of *R v Johnston* (1903) 9 Argus L. R. (C.N.) 11 decided under the *Crimes Act* 1900 (N.S.W.) and considered below, 81.

Although Tasmania is the only jurisdiction where the absence of lawful excuse is an element of the offence, in the other Code jurisdictions, there is some room for arguing that the defence of lawful excuse is implicit in the statutory scheme. Some support for this view can be derived from the provision in all of the Codes, creating a separate offence of failing to provide necessities.³²⁵ Under the Code provisions, this offence is established if a person charged with the duty of providing necessities, fails to do so without lawful excuse. Since lawful excuse is a feature of these provisions dealing with the failure to provide necessities it could therefore be argued that it should apply uniformly in the interpretation of the duty provisions. And, as argued above,³²⁶ on this view, the refusal of treatment by a competent patient would constitute lawful excuse for omitting to perform duties involving the provision of medical treatment.

In conclusion, it is submitted that in the Australian Code jurisdictions, doctors can lawfully comply with the patient's refusal of treatment, even in circumstances where refusal of treatment amounts to consent to death. This is because the refusal of treatment by a competent patient terminates the doctor's duties under the Codes.³²⁷ Alternatively, it could be argued that since the patient had exercised his or her right to refuse treatment, the doctor had lawful excuse in omitting to perform his or her duty to patient. As was suggested earlier in the context of the common law position,³²⁸ there are strong arguments in favour of a uniform approach with regard to consent so that the common law right to refuse treatment is given recognition also for the purposes of the criminal law. It is also clearly desirable for there to be uniformity in the interpretation of the criminal law as between common law and Code jurisdictions.

Position Under the *Crimes Act 1900* (N.S.W.)

Consideration must also be given to the legal position under *Crimes Act 1900* (N.S.W.) regarding the effect of the patient's refusal of treatment upon the doctor's liability to provide that treatment. Although the definition of murder under s. 18 clearly covers omissions, as noted earlier,³²⁹ the Act relies upon the common law as the source of the relevant duties for the purposes of criminal liability. It follows, therefore, that the arguments advanced earlier with respect to the common law position³³⁰ apply with equal force under the *Crimes Act 1900* (N.S.W.) namely that the refusal of treatment by a competent patient has the effect of extinguishing any pre-existing duty of a doctor to provide treatment.

³²⁵ N.T. s. 183; Qld. s. 325; Tas. s. 177; W.A. s. 302. Note also ss. 215(2) and (3) of the Canadian *Criminal Code* 1985; s. 151(2) of the New Zealand *Crimes Act* 1961.

³²⁶ See above, 79.

³²⁷ See also the Law Reform Commission of Western Australia, *Medical Treatment for the Dying*, 4 for support for this view.

³²⁸ See above, 74-75.

³²⁹ See chapter I, 21-22.

³³⁰ See above, 74-75.

An alternative argument open under the *Crimes Act* 1900 (N.S.W.) is based upon the defence of lawful excuse discussed earlier in the context of the Criminal Codes.³³¹ In the proviso to the definition of murder in s. 18 of the *Crimes Act* 1900 (N.S.W.) it is stated that 'no act or omission.. for which the accused had lawful cause or excuse, shall be within this section'. Thus, it could be argued that if a doctor, acting upon the patient's directions, omits to provide treatment and the patient's death results, the doctor has lawful cause or excuse for that omission, thereby effectively removing that conduct from within the scope of the prohibition on murder in s. 18.

An early New South Wales case which appears to support this proposition is *R v Johnston*.³³² That case involved criminal charges under the New South Wales *Crimes Act* 1900 against a husband for the murder of his wife on the ground that he had omitted, without lawful excuse, to send for a doctor when his wife's life was in danger. The facts were that the husband had offered to send for help but the wife had vigorously refused medical aid. Both the husband and wife were members of the Christian Catholic Church of Zion and held the belief that medical aid is unnecessary in cases of illness and also wrong in the sight of God.

Even though the husband had pleaded guilty to the charges of murder, Simpson J. directed the jury to acquit the defendant. His Honour was of the view that, having regard to the refusal of the wife to see a doctor, and the parties' belief that doctors were not necessary, lawful excuse for the omission within the meaning of the section was established on the facts. Although the facts of *R v Johnston* are somewhat removed from the more usual refusal of treatment situation, the case can be interpreted as authority for the view that the refusal of treatment by a competent patient constitutes lawful excuse for the omission to provide that treatment.

Conclusion

The object of this chapter has been to examine the legal effect of a patient's right to refuse treatment upon a doctor's legal duty to provide treatment. This has involved consideration of the patient's common law right to refuse treatment and the criminal law position regarding the legal status of consent of the victim in determining culpability for homicide.

Although the criminal law, both in common law jurisdictions and under the Codes, prevents the consent of the victim from being a valid defence to criminal charges, this does not affect the right of a patient to refuse treatment and the capacity of a doctor to lawfully comply with the patient's request, even though the patient's death may result. This is because the refusal of treatment by a competent patient eliminates a doctor's duty to provide treatment, both at common law and under the Codes, such that the failure to provide that treatment does not amount to a culpable omission and will not give

³³¹ See above, 79-80.

³³² (1903) 9 Argus Law Reports (C.N.) 11. See also the analysis of this case by Lanham, 'The Right to Choose to Die with Dignity,' 406-407.

rise to criminal liability. Thus, the scope of the doctor's duty ultimately lies within the control of a competent patient, by virtue of the patient's right to either consent to³³³ or refuse treatment or to terminate the doctor/patient relationship. This conclusion is sound in principle. The duty imposed by the criminal law exists primarily for the benefit of the patient, and it should therefore logically follow that a competent patient who has decided to forgo further treatment should have the capacity to terminate the doctor's duty to provide that treatment.

It follows from the foregoing analysis that a doctor may lawfully perform passive euthanasia at the request of a competent patient: i.e. he or she may deliberately withhold or withdraw treatment from a patient with the intention of facilitating the patient's death. This conclusion, in turn, highlights the law's starkly differential treatment of active and passive euthanasia. It was demonstrated in chapter I that a doctor who performs active euthanasia will potentially face criminal liability for murder even in circumstances where the acts causing death were performed at the patient's request. Yet, a doctor who withholds or withdraws treatment at the request of a competent patient, intending that the patient's death will result, will not be criminally liable for the patient's death. Thus, even though the object and end result of active and passive euthanasia are the same, the legal consequences differ widely.

³³³ Subject to the qualification that a patient cannot insist upon treatment which is not medically indicated. See discussion above, n. 4.

CHAPTER III

SUICIDE AND ASSISTED SUICIDE

Introduction

Apart from the potential criminal liability of a doctor for homicide it is also possible for a doctor who is involved in bringing about a patient's death to incur criminal liability for assisting suicide. The object of this chapter is to look at the law in relation to assisted suicide¹ and examine the circumstances in which a doctor may be subject to criminal liability for this offence. In the course of this analysis attention will be drawn to relevant analogies between the legal response to active and passive euthanasia on the one hand, as outlined in the preceding chapters, and assisted suicide on the other.

At common law, a person who committed suicide was regarded as a self-murderer or *felo de se* (felon against himself).² Consequently, anyone who instigated or aided another to commit suicide was guilty of murder as an accomplice.³ In all Australian jurisdictions suicide is no longer an offence. In the Australian Capital Territory, New South Wales, South Australia and Victoria, the offence of suicide has been abolished⁴ but a new statutory offence has been created which makes it an offence for a person to incite, counsel, aid or abet another to commit suicide or attempt to commit suicide.⁵ In the Code jurisdictions (the Northern Territory, Queensland, Tasmania and Western Australia) the Criminal Codes contain no specific offence of suicide and the definition of unlawful homicide in the Codes refers to the killing of 'another',⁶ thereby clearly excluding suicide from within its scope.⁷ Although suicide is no longer an offence, the Codes do proscribe instigating or aiding another to kill him or

¹ For the purposes of this discussion, the word 'assisted' suicide will be used as a shorthand way to describe the various terms, aid, abet procure etc.

² For a discussion of the history of suicide and its prohibition, see H. Trowell, *The Unfinished Debate On Euthanasia* (1973) 1-11 and G. Williams, *Textbook of Criminal Law* (2nd ed., 1983) 578.

³ L. Waller and C.R. Williams, *Brett, Waller and Williams Criminal Law* (6th ed., 1989) 120.

⁴ A.C.T. s. 16 *Crimes (Amendment) Ordinance (No. 2)* 1990 which modifies the operation of the *Crimes Act* 1900 (N.S.W) for the purposes of the law in the Australian Capital Territory; N.S.W. s. 31A of the *Crimes Act* 1900 as amended by the *Crimes (Mental Disorder) Amendment Act* 1983; S.A. s. 13(a)(1) *Criminal Law Consolidation Act* 1935 as amended by the *Criminal Law Consolidation Act Amendment Act* 1983; Vic. s. 6A of the *Crimes Act* 1958.

⁵ A.C.T. s. 17(1) and (2) *Crimes (Amendment) Ordinance (No. 2)* 1990; N.S.W. s. 31C(1) and (2) of the *Crimes Act* 1900 as amended by the *Crimes (Mental Disorder) Amendment Act* 1983; S.A. s. 13(a)(5) of the *Criminal Law Consolidation Act* 1935 as amended by the *Criminal Law Consolidation Act Amendment Act* 1983; and Vic. s. 6B(2) of the *Crimes Act* 1958 (Vic). In the absence of such legislation, assisted suicide would no longer have been unlawful following the abolition of the offence of suicide.

⁶ N.T. s. 161 *Criminal Code* 1983; Qld. s. 293 *Criminal Code* 1899; Tas. s. 153 *Criminal Code* 1924; W.A. s. 270 *Criminal Code* 1913. Note also s. 222 of the Canadian *Criminal Code* 1985; s. 158 of the New Zealand *Crimes Act* 1961.

⁷ *Howard's Criminal Law* (5th ed., 1990 by B. Fisse) 132.

herself.⁸ The Northern Territory is the only Australian jurisdiction in which attempted suicide is also an offence.⁹

The legal position in Australia in relation to suicide parallels developments in other common law jurisdictions. In England, the *Suicide Act* of 1961 abrogated the crime of committing suicide¹⁰ and created a new offence of 'aiding, abetting counselling or procuring the suicide of another'.¹¹ Similarly, in the United States, suicide is no longer a crime, but in quite a number of States, assisting suicide is a criminal offence.¹²

Some patients who are terminally ill or in intolerable pain will actively seek death and may endeavour to enlist the support of their doctor in achieving this result. Whilst there are, obviously, a number of possible scenarios, two particular situations need to be distinguished: 1) circumstances where a doctor, at the request of a patient, provides some form of active assistance in bringing about the patient's death (for example, providing a patient with the necessary medication to commit suicide and assisting in its administration); and 2) circumstances where a patient refuses treatment, knowing and intending that death should result and the doctor complies with the patient's refusal by withholding or withdrawing that treatment. In the former case, assisting suicide is almost indistinguishable from the killing of patients on request (or active voluntary euthanasia) which clearly constitutes murder.¹³ The latter category involving patient's refusal of treatment may not, at first sight, appear to be suicide at all but it will be argued that in certain circumstances, refusal of treatment is tantamount to suicide. Consideration therefore must be given to the legal position of a doctor who knowingly assists a patient with this purpose.

In the following section it is proposed to examine the legal requirements for liability for assisting suicide and to ascertain the legal liability of a doctor if he or she responds to a patient expressing the wish to die by either actively assisting the patient in taking his or her own life or by complying with the patient's wish that no further treatment be administered.

⁸ N.T. s. 168; Qld. s. 31; W.A. s. 288; which make it an offence to 'procure' or 'counsel' another to kill himself or 'aid' another in killing himself, and s. 163 of the Tasmanian Code which makes it an offence to 'instigate or aid another to kill himself'. Note also s. 241 of the Canadian *Criminal Code* 1985; s. 179 of the New Zealand *Crimes Act* 1961.

⁹ N.T. s. 169.

¹⁰ Section 1 *Suicide Act* 1961 (Eng.).

¹¹ Section 2(1). This legislation only applies in England and Wales. Suicide has never been an offence under Scottish law. No specific offence of assisting suicide exists but such conduct may be treated as culpable homicide.

¹² Some American States consider suicide assistance to be murder or manslaughter. However, the majority of States that have statutes imposing criminal liability for assisting a suicide have done so by creating a separate offence of suicide assistance. See C. Shaffer, 'Criminal Liability for Assisting Suicide' (1986) 86 *Colum.L.Rev.* 348, 350-353. For consideration of the position in Canada, see A. Browne, 'Assisted Suicide and Active Voluntary Euthanasia' (1989) 2 *Can.J.L.Juris.* 35, 35-36. As in England and Australia, suicide and attempted suicide has been legalised but assisting suicide remains a crime; see s. 241 of the Canadian *Criminal Code* 1985. The relevant legislation in New Zealand is the *Crimes Act* 1961, s.179; for discussion, see P. Key, 'Euthanasia: Law and Morality' (1989) 6 *Auckland U.L.Rev.* 225, 229.

¹³ See, however, R. Weir, 'The Morality of Physician-Assisted Suicide' (1992) 20 *Law, Med. & Health Care* 116, 117-118 where he suggests that there are a number of significant differences between active voluntary euthanasia and assisted suicide.

Assisting Suicide: The Legal Requirements

As was outlined earlier,¹⁴ following the abolition of the offence of suicide in all Australian jurisdictions, a new statutory offence of assisting suicide was created.¹⁵ In the Australian Capital Territory, New South Wales, South Australia and Victoria, it is an offence to 'incite, counsel, aid or abet another to commit suicide or attempt to commit suicide'.¹⁶ The Criminal Codes in the Northern Territory, Queensland and Western Australia make it an offence to 'procure or counsel another to kill himself or aid another in killing himself'¹⁷ and under the Tasmanian Code, it is an offence to 'instigate or aid another to kill himself'.¹⁸ The provision made in the various Australian jurisdictions closely parallels that contained in the *Suicide Act* 1961 (Eng.) which makes it a statutory crime to 'aid, abet, counsel or procure' a person to commit suicide.¹⁹ Although there are some variations in the wording of these various provisions, they are all essentially directed at prohibiting any conduct which involves assisting suicide.²⁰ In those jurisdictions where abetting suicide is also prohibited the scope of the provision is wider. The terminology used in these provisions (aid, abet, incite, counsel, procure etc.) is the same as that commonly used to define secondary participation in crime. As a result, some guidance can be obtained in the interpretation of the assisting suicide provisions from existing Australian authority dealing generally with parties to crime. Prosecutions for assisting suicide rarely arise and there is as a result, very little direct judicial authority in Australia regarding the interpretation of these assisting suicide provisions.²¹ Decisions from other jurisdictions, based upon equivalent statutory provisions, are therefore likely to be particularly relevant.

In the English case of *Attorney-General v Able*²² the court was called upon to consider s. 2(1) in the *Suicide Act* 1961 (Eng.) which contains the statutory offence of aiding, abetting, counselling or procuring a person to commit suicide. This case involved the distribution of a booklet entitled 'A Guide to Self-Deliverance' by the Voluntary Euthanasia Society to members of the society. The booklet contained information about various methods of suicide and was prepared with the expressed

¹⁴ See above, 83-84.

¹⁵ The statutory prohibition is in the nature of a principal offence and will therefore give rise to liability for *attempt* to aid, abet suicide etc. even though the person concerned did not actually attempt suicide. See J.C. Smith and B. Hogan, *Criminal Law* (5th ed., 1983) 336; *Attorney-General v Able* [1984] 1 All E.R. 277, 285, citing *R v McShane* (1977) 66 Cr. App. R. 97.

¹⁶ See above, n. 5.

¹⁷ N.T. s. 168; Qld. s. 311; W.A. s. 288.

¹⁸ Section 163. The term 'instigate' is defined in the interpretation part of the Act to mean 'counsel procure or command'.

¹⁹ *Suicide Act* 1961 (Eng.) s. 2(1). See also s. 241 of the Canadian *Criminal Code* 1985; s. 179 of the New Zealand *Crimes Act* 1961.

²⁰ See J.K. Bentil, 'Voluntary Euthanasia and the Criminal Law' (1984) 128 *Solic.J.* 826, 826 for analysis of the words 'aid, abet, counsel and procure' in the *Suicide Act* 1961 (Eng.).

²¹ There are only a handful of unreported cases in Australia and these have generally involved pleas of guilty. As a result, little or no attention has been directed to the interpretation of the relevant legislation. See, for example, *R v Larkin* (unreported) 14 April 1983, S.C. Vic.; *R v Den Heyer* (unreported) 28 Sept. 1990, Paramatta D.C. N.S.W.; *R v Savage* (unreported) 28 March 1992, Newcastle D.C., N.S.W.

²² [1984] 1 All E.R. 277.

aim of overcoming people's fear of dying and to reduce the incidence of unsuccessful suicides. The booklet also sought to discourage hasty and ill-considered suicide attempts.

In a civil action brought by the Attorney-General against members of the society's executive committee, a declaration was sought that the future supply of the booklet to persons who were known to be, or likely to be, considering or intending to commit suicide, constituted the offence of aiding, abetting, counselling or procuring the suicide of another, contrary to s. 2(1) of the *Suicide Act* 1961 (Eng.). Although no final determination was made as to whether the distribution of the booklet was in contravention of the legislation,²³ Justice Woolf did offer some guidance with respect to the interpretation of the provision. His Honour was of the view that in the ordinary case, in deciding whether an offence has been committed, it is preferable to consider the phrase 'aids, abets, counsels or procures' as a whole, but recognised that circumstances could arise which would justify interpreting part of the phrase in isolation. With respect to the meaning of the terminology used in the section, his Honour indicated that whilst 'aiding' requires some form of assistance, it does not require consensus between the accessory and principal or a causal connection between the conduct of the accused and the commission of suicide.²⁴ 'Abetting' and 'counselling' on the other hand, imply consensus but not causation²⁵ and 'procuring' implies causation but not necessarily consensus.²⁶ His Honour went on to make it clear that in order for liability to be established under s. 2(1) of the *Suicide Act* 1961 (Eng.) it must be proved that:

- (1) the accused intended to assist a person to commit suicide;
- (2) while the accused had that intention, he or she provided some assistance to the person contemplating suicide;
- (3) that the person committing suicide was thereby in fact assisted or encouraged in taking, or attempting to take his or her own life - (otherwise the alleged offender cannot be guilty of more than an attempt).²⁷

With respect to the necessary intention, it was held that an intention to assist another to commit suicide need not involve a desire that suicide should be committed or attempted.²⁸ Moreover, if these facts can be proved, then it does not make any difference that the person would have tried to commit suicide anyway.²⁹

Although Justice Woolf's interpretation of s. 2(1) of the *Suicide Act* 1961 (Eng.) was made in the context of civil proceedings, his views would be likely to be considered the clearest guide to the

²³ Since the declaration sought could result in treating as criminal conduct which was not in contravention of the criminal law, the declaration was refused.

²⁴ [1984] 1 All E.R. 277, 287.

²⁵ *Ibid.*

²⁶ *Id.* 287-8, also citing Lord Widgery C.J. in *A.G.'s Reference (No. 1 of 1975)* [1975] Q.B. 773.

²⁷ *Id.* 288.

²⁸ For further discussion of the *mens rea* requirement for the offence of suicide under s. 2 of the *Suicide Act* 1961 (Eng.) see K. Smith, 'Assisting Suicide - The Attorney General and the Voluntary Euthanasia Society' (1983) *Crim.L.Rev.* 579.

²⁹ [1984] 1 All E.R. 277, 288.

criminal law position in England. In view of the similarity between this provision and the prohibitions on assisting suicide in the various Australian jurisdictions, the reasoning of Woolf J. is likely to be persuasive in Australia alongside existing Australian authority dealing generally with parties.

A Doctor's Liability for Active Involvement in a Patient's Suicide

In view of the statutory prohibition on assisting suicide and the judicial interpretation it has received, it is readily apparent that a doctor who actively assists a patient to commit suicide will incur criminal liability. Common to all of the statutory provisions is the prohibition on 'aiding suicide' which clearly involves some form of assistance in a person's suicide.³⁰ To establish a person's guilt as an aider and abettor, it is necessary to show that the person was intentionally assisting or encouraging the commission of the act in question or that he or she was at least ready to assist if required.³¹ The prohibition on 'aiding and abetting' suicide is also of direct relevance in the medical context since a doctor who, at a patient's request, provides the means of committing suicide is, without doubt, aiding the patient's suicide. Furthermore, there would be no difficulty in establishing that the doctor thereby intended to assist the patient to commit suicide, (irrespective of whether he or she desired that result) and that the patient was in fact assisted or encouraged in taking, or attempting to take his or her own life. In circumstances where the doctor has provided the patient with information and advice, for example, regarding the toxicity of drugs and what would amount to a lethal dose, the doctor's conduct may also attract liability on the basis of 'counselling'³² or even 'procuring' the patient's suicide.³³ Once the basis for liability is made out under the statutory prohibition, the special features which arguably set a doctor's conduct apart from other forms of criminal conduct are irrelevant.³⁴ Thus, the fact that the doctor was acting *bona fide* and that assistance was provided at request of the patient would not exculpate a doctor from criminal liability. Furthermore, it would be irrelevant that the patient was in a terminal condition and that the patient's death was in any event imminent.

When one comes to consider the factual situations which would come within the statutory prohibition of assisting suicide, it becomes evident that there is, in practice, a fine line between assisting suicide and active voluntary euthanasia which, as we have seen, constitutes murder. Essentially, it all depends

³⁰ *Attorney-General v Able* [1984] 1 All E.R. 277.

³¹ For reference to relevant cases see below.

³² A.C.T. s. 17(2) *Crimes (Amendment) Ordinance (No. 2)* 1990; N.S.W. s. 31C(2) of the *Crimes Act* 1900 as amended by the *Crimes (Mental Disorder) Amendment Act* 1983; S.A. s. 13(a)(5) of the *Criminal Law Consolidation Act* 1935 as amended by the *Criminal Law Consolidation Act Amendment Act* 1983; N.T. s. 168 (b); Qld. s. 311(2); W.A. s. 288(2). Note also s. 179(a) of the New Zealand *Crimes Act* 1961. The legislation in the Australian Capital Territory, New South Wales and Victoria also contains a prohibition on inciting another person to commit suicide; see s. 17(2)(a); s. 31C(2)(a); and s. 6B(2)(a) respectively.

³³ N.T. s. 168(b); Qld. s. 311(1); W.A. s. 288(1). Note also s. 179(a) of the New Zealand *Crimes Act* 1961.

³⁴ See, however, the suggestion that existing 'right to die' jurisprudence in the United States could be extended to cover physician-assisted suicide; for example, the prescription of drugs at the patient's request that would end the life of a terminally ill, mentally competent patient; Note, 'Physician-Assisted Suicide and the Right to Die with Assistance' (1992) 105 *Harv.L.Rev.* 2021, 2023.

on the degree of the doctor's involvement. Active assistance in suicide amounts to murder if death occurs as a result of an overt act of the 'assistant'.³⁵ Where, however, there has simply been participation in the events leading up to the commission of the final overt act, such as providing the means for bringing about death for the patient's own use, the doctor's conduct comes within the prohibition on assisting suicide.³⁶ Notwithstanding the apparent simplicity of this classification, difficulties may yet arise in determining the appropriate charge in any given case and instances of consent killing are occasionally reduced to assisting suicide.³⁷

Refusal of Treatment as Suicide and the Legal Position of Doctors

In the foregoing part, it was noted that if a doctor provides active assistance to a patient wishing to commit suicide, by providing the means by which the suicide is to be effected, the doctor will incur criminal liability under the statutory provisions prohibiting assisted suicide. The fundamental question which now arises for determination is whether a doctor's compliance with a patient's refusal of treatment can ever amount to assisting suicide. In order to answer this question, attention must be directed to the following matters:

- (1) Can the refusal of treatment by a patient ever amount to suicide?³⁸
- (2) If, in some circumstances, the refusal of treatment *can* amount to be suicide, is a doctor who accedes to a request by a patient to cease treatment criminally liable for assisting suicide?

For the purposes of Australian law, the difficulty is that there is virtually no authority, either on the subject of assisted suicide or the right of a patient to refuse treatment and as a result, there is little guidance as to how the courts are likely to decide these questions. It therefore becomes necessary to extrapolate the relevant legal principles from the authority which is available and examine their potential relevance in Australia and other common law jurisdictions.

Elsewhere, consideration has been given to the fundamental right of a competent patient at common law to refuse treatment including life-saving treatment.³⁹ The question which now arises for

³⁵ For American case law on this issue see *State v Bouse* 264 P. 2d 800, 812 (1953); *State v Cobb* 625 P. 2d 1133 (1981); *In re Joseph G* 34 Cal. 3d 429 (1983). See also V. Gilbreath, 'The Right of the Terminally Ill to Die with Assistance if Necessary' (1986) 8 *Crim.Just.J.* 403, 419.

³⁶ *In re Joseph G* 34 Cal. 3d 429 (1983). It has, however, been argued that notwithstanding statutory prohibitions on aiding or instigating suicide, the conduct of the defendant may also constitute murder on the basis of common law principles of causation; see D. Lanham, 'Murder by Instigating Suicide' (1980) *Crim.L.Rev.* 215, 220-221. This suggestion has been rejected by Williams, 578 n.3.

³⁷ Williams, 580. This is also a reflection of the lenient approach of the law in practice in genuine cases of mercy killing or assisted suicide. For further discussion see chapter IV, 123-146.

³⁸ It should be understood that although suicide is no longer an offence, the question of whether particular conduct constitutes suicide in law is still relevant for the purposes of determining liability for the offence of assisting suicide.

³⁹ Chapter II, 33-37, 41-42.

determination is whether the exercise of this right can ever amount to suicide.⁴⁰ It is therefore necessary to examine more closely the notion of suicide and its legal requirements.

From the outset, it should be acknowledged that there are some practical obstacles in settling upon an adequate definition of suicide. Suicide has traditionally been anathema in Judaeo-Christian culture, evoking both popular condemnation and legal intervention.⁴¹ Although the law no longer treats suicide or attempted suicide as a crime,⁴² in contemporary society, suicide is still socially disapproved of and there are a variety of common legal provisions which reflect continued societal concern over the phenomenon of suicide.⁴³ Consequently, attempts to define suicide are likely to reflect this social disapproval,⁴⁴ and conduct which is regarded as socially acceptable may well fall outside the scope of the accepted definition of suicide.⁴⁵

According to the traditional legal definition at common law, suicide is the intentional, voluntary taking of one's own life by a person of sound mind and of the age of discretion.⁴⁶ It remains now to be considered how refusal of treatment has been characterised and whether it can ever amount to suicide.

Suicide by Omission

A preliminary question of some importance is whether there can be suicide by omission. By definition, suicide involves the taking of one's own life so the question for determination is whether this must be by some positive conduct or whether an omission to act could amount to suicide. Williams has suggested that inaction cannot be suicide in law.⁴⁷ It is certainly true that suicide is

⁴⁰ This discussion is confined to the position of patients who have decision-making capacity, since patients lacking that capacity would be unable to form the necessary intention to commit suicide. It should also be pointed out that what is being considered here is the refusal of treatment by a patient who has decision-making capacity as distinguished from the situation where a person has inflicted injury upon themselves in an attempted suicide and then refuses necessary life-saving treatment.

⁴¹ N. Cantor, *Legal Frontiers of Death and Dying* (1987) 46.

⁴² Attempted suicide remains a crime in the Northern Territory; see s. 169 *Criminal Code* 1983.

⁴³ Cantor, 46 where he refers to the prohibitions with regard to aiding and abetting suicide, the fact that persons are often hospitalised for psychiatric scrutiny after a suicide attempt, and the fact that bystanders are authorised to use reasonable force to thwart a suicide attempt.

⁴⁴ T. Beauchamp and S. Perlin, (eds.) *Ethical Issues in Death and Dying* (1978) 88, 97-7; R. Wennberg, *Terminal Choices* (1989) 17-18.

⁴⁵ See also J. Rachels, *The End of Life* (1986) 82. Note should also be taken of the religious position in respect of refusal of treatment and suicide. In the Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* Vatican City (1980) it was stated that a patient's refusal of risky or burdensome treatment 'is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.' The corollary is that according to Catholic teaching, refusal of ordinary treatment does amount to suicide.

⁴⁶ *Clift v Schwabe* (1846) 3 C.B. 437, approved in *Re Davis* [1968] 1 Q.B. 72. See also N. St. John Stevas, *Life, Death and the Law* (1961) 242 where he notes that the definition of suicide generally adopted in the United States is the same as in England, and refers to the case of *Southern Life and Health Insurance Co. v Wynn* 29 Ala. App. 207 (1940).

⁴⁷ Williams, 613. See also I. Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors' (1976) *Crim.L.Rev.* 217, 226 where he questions whether the omission/commission dichotomy applies to suicide.

typically associated with affirmative conduct such as taking an overdose of tablets or jumping to one's death.⁴⁸ Indeed, the 'cide' in the word suicide entails 'killing' which is commonly contrasted with 'allowing to die'.⁴⁹ However, as Lanham suggests⁵⁰ there seems to be no reason in principle why suicide cannot be committed by an omission. Provided there is suicidal intent, omissions resulting in death are not relevantly different from acts. For example, if a person deliberately chooses not to move from the path of an avalanche, or refuses to leave a burning building, it is arguable that the person is committing suicide.⁵¹ Furthermore, recognition of the possibility of suicide by omission would be consistent with the widespread rejection of technical distinctions between acts and omissions.⁵²

There is some, albeit modest, judicial support for the view that there can be suicide by omission. The English case of *Leigh v Gladstone*⁵³ has been cited in support of this proposition.⁵⁴ This case involved the forcible feeding of a suffragette prisoner who was on a hunger strike. Although the issue of preventing suicide was not specifically raised, the court held that the prison officials had a duty to preserve the lives of prisoners and were consequently justified in force-feeding the prisoner.⁵⁵ This decision can be rationalised on the basis that the conduct of the prisoner in refusing food was tantamount to suicide (then a felony) and the prison officials were therefore entitled (*quaere* obliged) to use force to prevent the prisoner from committing suicide by starving herself to death.⁵⁶

There is also some Australian authority in support of the proposition that there may be suicide by omission. In *Schneidas v Corrective Services Commission*⁵⁷ the court was called upon to determine the legal position of prison authorities with respect to a prisoner who had gone on a hunger strike. Justice Lee of the New South Wales Supreme Court was of the view that the prisoner, by denying his body necessary food, was in the course of attempting to commit suicide. His Honour accordingly

⁴⁸ Cantor, 47. See also Hale, *Pleas of the Crown* (1736) (where suicide or *felo de se* is defined to be 'where a man of the age of discretion, and *compos mentis*, voluntarily kills himself, by stabbing, poison or any other way') and the interpretation of suicide in *Clift v Schwabe* (1846) 3 C.B. 437.

⁴⁹ Beauchamp and Perlin, 99. For discussion of the distinction between 'killing' and 'allowing to die' see chapter IV, 158-159.

⁵⁰ D. Lanham, 'The Right to Choose to Die with Dignity' (1990) 14 *Crim.L.J.* 401, 408. See also M. Matthews, 'Suicidal Competence and the Patient's Right to Refuse Life-Saving Treatment' (1987) 74 *Calif.L.Rev.* 707, 740; J. Fletcher, *Humanhood* (1979) 157; G. Grisez 'Suicide and Euthanasia' in D. Horan and D. Mall, (eds.) *Death, Dying and Euthanasia* (1980) 742, 745.

⁵¹ Cantor, 47. This analysis is consistent with the definition of suicide proposed by the eminent sociologist Emil Durkheim; 'The term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce this result.' E. Durkheim, *Suicide* (J. Spaulding and G. Simpson translation 1951) 44.

⁵² For example, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 60-77. (Hereafter referred to as the President's Commission Report.)

⁵³ (1909) 26 T.L.R. 139.

⁵⁴ For example, Lanham, 'The Right to Choose to Die with Dignity', 408.

⁵⁵ (1909) 26 T.L.R. 139, 142. For criticism of this decision see Williams, 617.

⁵⁶ For an analysis of this decision see G. Zellick, 'The Forcible Feeding of Prisoners: An Examination of the Legality of Enforced Therapy' (1976) *Pub. Law* 153, 163.

⁵⁷ (Unreported) 8 April 1983, S.C. N.S.W. At the time of this decision, suicide was still an offence in the State of New South Wales. Whilst this may explain the reluctance of the court to be involved in the suicide attempt, it does not affect the court's characterisation of the prisoner's refusal of food as an attempt to commit suicide.

refused to grant an injunction preventing force-feeding, because to do so would, in effect, involve the court in aiding and abetting the commission of a crime.⁵⁸

A similar approach has been taken by the American and Canadian courts in a number of prisoner cases. In *In re Caulk*,⁵⁹ a prisoner sentenced to life imprisonment had decided to starve himself to death and the court was called upon to consider whether the prison authorities could lawfully force-feed the prisoner. The Supreme Court of New Hampshire held that the prisoner's decision to starve himself to death amounted to attempted suicide and since aiding and abetting suicide was a crime, the prison authorities could lawfully force-feed the prisoner.⁶⁰ There is also Canadian authority to the effect that refusal of food by a prisoner may amount to suicide.⁶¹ Apart from the prisoner cases, there have been other instances of judicial recognition that there can be suicide by omission.⁶²

It is submitted that as a matter of law, suicide can be committed by an omission. This conclusion is not inconsistent with the traditional common law definition of suicide (i.e. the voluntary and intentional taking of one's own life) and derives some support from the modern case law. More importantly, however, this view is supportable as a matter of principle and logic.⁶³ There appears to be no valid basis for categorically holding that suicide can only be committed by affirmative conduct and that inaction cannot amount to suicide at law.

Refusal of Treatment as Suicide?

On the assumption that in principle, suicide can be committed by omission, it is necessary to specifically consider whether the refusal of treatment by a patient can ever amount to suicide. It must be emphasised that since suicide or attempted suicide are no longer criminal offences,⁶⁴ the significance of this question lies in determining the legal liability of persons who assist another to commit suicide.

⁵⁸ For comment on this decision, see M. Findlay, 'Hunger Strikes and the State's Right to Force Feed - Recent Australian Experience' (1984) 19 *Ir. Jurist* 304 and I. Potas, '*Schneidas v Corrective Services Commission and Ors*' (1983) 7 *Crim.L.J.* 353.

⁵⁹ 480 A. 2d 93 (1984).

⁶⁰ See also *State ex rel White v Narick* 292 S.E. 2d 54 (1982); *Re Sanchez* 577 F.S. 7 (1983); *Van Holden v Chapman* 450 N.Y.S. 2d 623 (1982). Cf. *Zant v Prevatte* 286 S.E. 2d 715 (1982). Lanham has, however, criticised these cases on the grounds that the typical hunger striker is not a would-be suicide since they do not actively seek death but rather life on their terms; 'The Right to Choose to Die with Dignity,' 409.

⁶¹ See *A.G. of British Columbia v Astaforoff and A.G. of Canada* [1984] 4 W.W.R. 385 in which it was held that whilst the patient is competent and able to make a free choice, it would be unreasonable for prison authorities to force-feed her in order to prevent her suicide and they were under no duty to do so.

⁶² See, for example, the dissenting judgment of Lynch J. in *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626, 642-643 (1986).

⁶³ N. Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life' (1973) 26 *Rutgers L.Rev.* 228, 255 n. 133 where he suggests that efforts to distinguish suicide from refusal of treatment on the basis of misfeasance versus non-feasance or the immorality of affirmative actions as opposed to passive refusal are unconvincing. See also Matthews, 740; R. Sherlock, 'For Everything there is a Season: The Right to Die in the United States' (1982) *B.Y.U.L.Rev.* 545, 557-558.

⁶⁴ Attempted suicide remains an offence in the Northern Territory; see above, 84.

It appears to be commonly assumed that refusal of treatment by a patient is not tantamount to suicide.⁶⁵ This assumption has undoubtedly been encouraged by the widespread recognition and approval of the patient's common law right to refuse medical treatment, since, as noted earlier, our conception of suicide is influenced by contemporary attitudes.⁶⁶ It must, however, be questioned whether the notion of suicide and the right of a patient to refuse treatment are necessarily mutually exclusive. It will be argued that, as a matter of legal principle, it is quite possible that a patient who exercises his or her right to refuse life-saving medical treatment is in fact committing suicide.⁶⁷

As was noted in the preceding chapter,⁶⁸ case law regarding the patient's refusal of treatment and the legal effects of such a refusal has emerged almost entirely from the United States and there is a dearth of Australian authority in this area. The Australian courts have not, to date, been called upon to directly adjudicate upon whether the refusal of treatment by a patient can amount to suicide. The meagre case law which does exist in Australia has involved related issues which have not directly raised the refusal of treatment and suicide analogy.⁶⁹ Whilst it could be argued that the unreported New South Wales decision in *Schneidas v Corrective Services Commission* considered earlier,⁷⁰ lends some modest support to the view that refusal of treatment may constitute suicide, Australian courts when directly faced with these issues are likely to be influenced by the same policy considerations which appear to have shaped the judicial response in the United States. Thus, in view of the social stigma still attached to suicide, and the tendency to avoid using the label 'suicide' in respect of conduct which we approve, the courts in Australia may well decide to follow the approach taken in the United States and distinguish refusal of treatment from suicide. It is therefore appropriate to examine the American cases dealing with these matters and to assess their significance in Australia and other common law jurisdictions.

⁶⁵ For example, the Parliament of Victoria Social Development Committee was of the view that a patient who refuses treatment which cannot cure is not committing suicide and stated that there is a 'clear distinction between suicide and an individual's enforceable right at common law to refuse medical treatment'; Parliament of Victoria Social Development Committee, Second and Final Report, *Inquiry into Options for Dying with Dignity* (1987) 107.

Some commentators have been critical of this kind of approach and have argued that the refusal of necessary life-sustaining treatment is a form of suicide; see Sherlock, 558-9; C. Rice, *The Vanishing Right to Life* (1969) 83; K. Hegland, 'Unauthorised Rendition of Lifesaving Medical Treatment' (1965) 53 *Calif.L.Rev.* 860, 869-871.

⁶⁶ See above, 89.

⁶⁷ See also D. Mendelson, 'The Medical Treatment (Enduring Power of Attorney) Act and Assisted Suicide: The Legal Position in Victoria' (1992) Vol. 12 No. 1 *Bioethics News* 34 where specific consideration is given to the scope of a refusal of treatment under the *Medical Treatment Act* 1988 (Vic.) and related legislation.

Some commentators take the view that refusal of life-saving medical treatment does not amount to suicide; see, for example, Lanham, 'The Right to Choose to Die with Dignity', 407-410; D. Lanham and B. Fehlberg, 'Living Wills and the Right to Die with Dignity' (1991) 18 *Melbourne U.L.Rev.* 329, 335-336.

⁶⁸ See chapter II, 33, 45-46.

⁶⁹ See the New South Wales case of *Schneidas v Corrective Services Commission* (unreported) 8 April 1983, S.C. N.S.W. involving a prisoner on a hunger strike (discussed above, 90-91) and the Victorian decision of *Re Kinney* (unreported) 23 Dec. 1988, S.C. Vic. (discussed below, 104) in which the medical condition requiring life-saving treatment had been brought about by an attempt to commit suicide.

⁷⁰ See above, 90-91.

The Position in the United States

In a number of the earlier refusal of treatment cases arising in the United States the courts drew an analogy between a patient's refusal of treatment and suicide, thereby justifying the courts decision to override the patient's refusal of treatment.⁷¹ So, for example, in *John F. Kennedy Memorial Hospital v Heston*⁷² the court ordered that a blood transfusion be administered to a Jehovah's Witness who had been seriously injured in a car accident. It was held by the court that:

If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other...the State's interest in sustaining life in such circumstances is hardly distinguishable from its interest in the case of suicide.⁷³

Accordingly, the State's interest in the prevention of suicide and the preservation of life was held to outweigh the patient's right to decline medical treatment.

In more recent cases, however, the courts have consistently distinguished between suicide and the refusal of treatment by a patient⁷⁴ and consequently, the State's interest in the prevention of suicide has not arisen.⁷⁵ The basis for differentiating between refusal of treatment and suicide rests on two main grounds. According to the traditional conception of suicide, as interpreted in a number of American cases, there must be: 1) a specific intention to bring about death; and 2) a self-initiated action which causes death. In the more recent refusal of treatment cases, the courts have tended to find both these elements of suicide to be absent.⁷⁶ Refusal of treatment by patients has been interpreted by the courts as being aimed at avoiding unwanted treatment, pain or the violation of religious principles, rather than causing one's own death, and therefore the specific intent element has been held

⁷¹ For example, *Application of the President and Directors of Georgetown College Inc.* 331 F. 2d 1000 (1964); *John F. Kennedy Memorial Hospital v Heston* 58 N.J. 576 (1971). Cf. *Erickson Dilgard* 252 N.Y. S. 2d 705 (1962). For a discussion of the early case law, see L. Sandak, 'Suicide and the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases' (1977-78) 44 *Brooklyn L.Rev.* 285, 299-302. These cases can, perhaps, be explained on the basis that at the time they were decided, the principles in respect of refusal of treatment were still in their formative stages. Moreover, they can also be factually distinguished from many of the later 'right to die' cases on the basis that the treatment which was refused was capable of restoring the patient to health.

⁷² 58 N.J. 576 (1971).

⁷³ *Id.* 581-2.

⁷⁴ For example, *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 426 (1977); *Satz v Perlmutter* 362 So. 2d 160, 162-163 (1978); *Bartling v Superior Court* 163 Cal. App. 3d 186, 196 (1984); *In re Conroy* 486 A. 2d 1209, 1224 (1985); *Bouvia v Superior Court* 225 Cal. Rptr. 297, 306 (1986); *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626, 638 (1986); *In re Farrel* 529 A. 2d 404, 411 (1987). There have, however, been a few isolated exceptions; see the dissenting judgments of Nolan, Lynch and O'Connor J.J. in *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986); the decision of the Missouri Supreme Court in *Cruzan v Harmon* 760 S.W. 2d 408 (1988), per Robertson J. 419-422; and the concurring judgment of Justice Scalia of the United States Supreme Court in *Cruzan v Director, Missouri Department of Health* 111 L. Ed. 2d 224, 251-156 (1990).

Note should also be made of the living will legislation existing in many American States which specifically provides that the withholding or withdrawing of treatment in accordance with a patient's directive does not constitute suicide. For further discussion, see chapter VII, 329. In some cases, the courts have relied on this legislation in support of the view that the refusal of treatment does not constitute suicide; e.g. *In re Colyer* 99 Wash. 2d 114 (1983).

⁷⁵ See chapter II, 51-52.

⁷⁶ For example, *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 426 (1977); *Satz v Perlmutter* 362 So. 2d 160, 162-163 (1978); *Bartling v Superior Court* 163 Cal. App. 3d 186, 196 (1984); *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626, 638 (1986).

to be absent.⁷⁷ Furthermore, since the courts have considered the underlying disease or injury - and not the withholding or cessation of treatment - to be the cause of death, they have not considered suicidal refusals to be affirmative acts causing death.⁷⁸ The approach of the courts in the United States is well illustrated by *In re Conroy*⁷⁹ in which the Supreme Court of New Jersey specifically rejected the analogy between refusal of treatment and suicide and held that a refusal of medical treatment may not properly be viewed as an attempt to commit suicide:

Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of self-inflicted injury⁸⁰....In addition, people who refuse life-sustaining medical treatment may not harbour a specific intent to die,... rather they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs and without protracted suffering.⁸¹

The relevant issues in this area were starkly raised in the case of *Bouvia v Superior Court*.⁸² As noted in the preceding chapter,⁸³ this case involved a competent 28 year old quadriplegic who required permanent hospitalisation but whose condition was not terminal.⁸⁴ In 1983 Elizabeth Bouvia had expressed the wish to commit suicide and had unsuccessfully sought permission from the court to starve herself to death. In 1986 she again applied to the court, seeking an injunction against her doctors, ordering that the naso-gastric tube with which she was being force-fed be removed. The trial court refused to grant the relief sought. Bouvia then appealed to the California Court of Appeal.

The Court of Appeal held that a competent adult has an absolute right to refuse life-saving treatment, including nourishment and hydration, even if the exercise of this right creates a life-threatening condition.⁸⁵ The court rejected arguments that the naso-gastric feeding be maintained in furtherance of the State's interests in the prevention of suicide and the preservation of life. Although Bouvia had claimed she did not wish to commit suicide, the trial court had found that she was motivated by a desire to end her life. This view was rejected by the Court of Appeal on the grounds that it was not supported by the evidence. The court effectively evaded the suicide issue by holding that her refusal of medical treatment indicated a decision to 'allow nature take its course' rather than a decision to commit suicide.⁸⁶ In the view of the court, Bouvia was not actively seeking to end her life but had merely resigned herself to an earlier death without force-feeding.⁸⁷ Although the court had concluded that her rejection of naso-gastric feeding was not motivated by a desire to commit suicide, the Court of Appeal

⁷⁷ Matthews, 735-736.

⁷⁸ *Id.* 736.

⁷⁹ 486 A. 2d 1209 (1985).

⁸⁰ This approach has also been endorsed in Canada by the Quebec Superior Court in the case of *Nancy B. v Hotel-Dieu de Quebec et al* 69 C.C.C. (3d) (1992) 450, 458, 460.

⁸¹ *Id.* 1224.

⁸² 225 Cal. Rptr. 297 (1986).

⁸³ See chapter II, 55.

⁸⁴ She had been diagnosed as likely to live for a further 15 or 20 years; see the Report at 304-305.

⁸⁵ 225 Cal. Rptr. 297, 300-301 (1986).

⁸⁶ *Id.* 306.

⁸⁷ *Ibid.*

was prepared to concede that in any event, it was irrelevant whether or not she desired to commit suicide because 'if the right to refuse treatment exists, it matters not what 'motivates' its exercise'.⁸⁸ This latter proposition appears to acknowledge, implicitly at least, that a refusal of treatment by a patient *may* amount to suicide but suggests that the right to refuse treatment is virtually absolute and will be upheld regardless of whether the exercise of that right is tantamount to suicide.⁸⁹ However, apart from this concession, which was in any event *obiter*, the approach taken by the *Bouvia* court was essentially in keeping with that articulated by other courts in the United States.⁹⁰

Thus, the suicide issue has been circumvented by the American courts. Regardless of the particular circumstances of the cases before the courts,⁹¹ the refusal of treatment by a patient has generally been distinguished from suicide. Consequently, the State's interest in the prevention of suicide has been held not to arise and further, the courts have been able to avoid the question of whether a doctor is unlawfully assisting suicide by complying with a patient's request that treatment be discontinued.

Analysis of the Approach Taken by the Courts in the United States

The approach of the American courts is to a large extent⁹² explicable on the basis of the patient's right of self-determination and the paramountcy which has been attached to that principle. According to Cantor,⁹³ both popular perception and judicial doctrine have come to regard a dying patient's refusal of treatment as a legitimate form of self-determination, thereby taking it outside the realm of suicide.⁹⁴ This widespread respect for individual bodily integrity and self-determination can be seen here to interact with another powerful consideration, namely the common societal aversion to suicide⁹⁵ and the tendency to tailor our conception of suicide so as to exclude behaviour which is regarded as acceptable.

⁸⁸ *Ibid.*

⁸⁹ L. Fisher, 'The Suicide Trap: *Bouvia v Superior Court* and the Right to Refuse Medical Treatment' (1987) 21 *Loy.L.A.L.Rev.* 219, 237.

⁹⁰ Note, however, the concurring judgment of Compton J., 307-308 in which the Judge acknowledged that Elizabeth Bouvia wanted to die and held that the right to die, 'an integral part of our right to control our own destinies', should include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.' This judgment obviously has far-reaching implications, being a rare instance of unequivocal judicial endorsement of active voluntary euthanasia and assisting suicide.

⁹¹ For example, the *Bouvia* case, where the patient was previously known to want to commit suicide, and where she had a relatively long life expectancy if she were to accept artificial feeding.

⁹² A number of other policy considerations underlying the courts' approach have been advanced; see, for example, Matthews, 737 where she suggests that the distinction between affirmative acts causing death and passive refusals of life-saving treatment reflects a general jurisprudential principle that the law should primarily prohibit misfeasance as opposed to non-feasance. Further, she points out that the passive fatalistic stance of a patient who allows an injury or disease to overtake him or her seems less disrespectful for the sanctity of life than the act of a person who violently kills him or herself.

⁹³ *Legal Frontiers of Death and Dying*, 47-49

⁹⁴ The position is less clear with regard to a patient whose condition is salvageable; Cantor, *Legal Frontiers of Death and Dying*, 49-50. Note also Matthews, 737 where she argues that the courts' approach may reflect a judicial unwillingness to distinguish good from bad reasons for patients' treatment decisions, and recognition of the need to protect individual decision-making, even with respect to unorthodox decisions.

⁹⁵ Cantor, *Legal Frontiers of Death and Dying*, 47; Rachels, 82-83.

Whilst there may be sound policy considerations underlying the courts' approach, it will be argued that the characterisation of a patient's refusal of treatment as falling *outside* the realm of suicide on the grounds that the patient lacks a specific intent to die and further, that refusal of treatment does not involve a self-initiated condition, lacks substance and results in an undesirable distortion of legal principles.⁹⁶

Absence of a 'Specific Intent' to Die

Under normal criminal law principles, an individual is generally taken to intend consequences which he or she knows will occur or which are reasonably foreseeable. However, for the purposes of the law of suicide, the courts have held that there must be evidence of a specific intent to die.⁹⁷ The requirement of a specific intent in the context of suicide has been justified on the basis that it avoids the inappropriate labelling of some conduct as suicide; for example, the conduct of a person who jumps in front of a car to save another, or who undertakes an heroic but mortally dangerous military mission.⁹⁸ This approach, in itself, demonstrates an adaption of legal principles in order to avoid the result that acceptable behaviour may be classified as suicide. But for present purposes, the major interest lies in the way in which the specific intent requirement is actually applied in the refusal of treatment cases. First of all, let us be clear on what is required by this 'specific intent' requirement. Mere knowledge or foresight of death will not be sufficient. A person has the necessary suicidal intent in circumstances where conduct causing death is deliberately undertaken in order to end his or her life and not for some other purpose.⁹⁹ There will inevitably be circumstances where treatment may be refused but the specific intent requirement may be lacking - for example, a Jehovah's Witness who refuses a blood transfusion on the grounds of religious principle but will accept other available treatment, or a patient who declines distasteful or burdensome treatment but does not thereby deliberately seek death.¹⁰⁰ However, it cannot be denied that in some instances, a patient's motives in refusing treatment are indistinguishable from suicidal intent.¹⁰¹ Take, for example, the situation of a terminally ill patient who declines further medical treatment in order to facilitate an earlier death. In such a case, the patient's rejection of treatment clearly entails a specific intent to die and suggestions to the contrary are simply semantic sleights of hand so as to avoid what is commonly regarded as an undesirable result; i.e. that the patient wishes to commit suicide. Even more obvious are cases where the patient's condition is salvageable or non-terminal and the patient refuses life-saving treatment with the clear intention of orchestrating his or her death; for example, a physically disabled patient who has lost the will to live and rejects further treatment, even nutrition and hydration.¹⁰² Here there is little

⁹⁶ For commentators criticising this approach see J. Fletcher, 'The Courts and Euthanasia' (1987-88) 15 *Law, Med. & Health Care* 223, 224-6; Cantor, *Legal Frontiers of Death and Dying*, 47; Matthews, 738; Sherlock, 554; G. Alexander, 'Death by Directive' (1988) 28 *Santa Clara L.Rev.* 82.

⁹⁷ *Re Davis* [1968] 1 Q.B. 72 and above, n. 74.

⁹⁸ Cantor, *Legal Frontiers of Death and Dying*, 47.

⁹⁹ See also K. Lebacqz and H.T. Engelhardt, 'Suicide' in Horan and Mall, 669, 670; Grisez, 745.

¹⁰⁰ Cantor, *Legal Frontiers of Death and Dying*, 47

¹⁰¹ Matthews, 738; C. Jarret, 'Moral Reasoning and Legal Change: Observations on the Termination of Medical Treatment and the Development of Law' (1988) 19 *Rutgers L.J.* 999, 1014-1016; P. Peters, 'The State's Interest in the Preservation of Life: From *Quinlan* to *Cruzan*' (1989) 50 *Ohio St.L.J.* 891, 964.

¹⁰² This was the situation in the *Bouvia* case, see above, 94-95.

room for doubt that the patient's decision to refuse treatment entails an intention to bring about his or her death.

Although in many instances, patients who refuse treatment are clearly seeking death, the courts in the United States have repeatedly held that they lack the necessary intent for that conduct to constitute suicide.¹⁰³ There has been a tendency to rationalise this conclusion on the basis that a patient who refuses life-saving treatment would really prefer to live, free of his or her afflictions.¹⁰⁴ This is a patent absurdity which, if followed through to its logical conclusion, would mean that a person deliberately taking his or her life would not be committing suicide if he or she wished it were not necessary.¹⁰⁵

No Self-Initiated Action Which Causes Death

In their attempts to distinguish refusal of treatment from suicide, the American courts have consistently held that the death of a patient following the withdrawal of treatment, is from 'natural causes', (i.e. the patient's underlying disease or condition) which were not initiated by the patient.¹⁰⁶ A distinction is then drawn between this situation and suicide which is said to require voluntary, self-initiated action causing death. This analysis is also open to criticism.¹⁰⁷ It was demonstrated earlier that the distinction between acts and omissions is not a valid basis for determining whether certain conduct can amount to suicide.¹⁰⁸ Thus, the refusal of necessary treatment is potentially as much a cause of death over which the person has control, as is the proverbial bottle of barbiturates.¹⁰⁹ The reality is that where death results following the patient's refusal of treatment, the death of the patient at that particular time is due to the patient's decision to die rather than the underlying condition of the patient.¹¹⁰ It is only because of the patient's decision to die and the subsequent refusal of treatment, that the natural processes are 'fatally set in motion.'¹¹¹

The inaccuracy of the current legal analysis is most clearly apparent in cases of refusal of treatment by non-terminal patients. Although the patient's death may be medically avoidable, and indeed the patient may have a potentially long life span if appropriate medical treatment were administered, the patient may decide to refuse further medical treatment. The patient's refusal may extend to nutrition and hydration or other minimally invasive life-saving treatment. In such cases, it is difficult to escape the conclusion that the patient has set in motion the cause of death, and if deliberately done for the

¹⁰³ See cases discussed above, 93-95.

¹⁰⁴ For example, *Satz v Perlmutter* 362 So. 2d 160, 162-3 (1978). For criticism of this approach, see Fletcher, 'The Courts and Euthanasia,' 225-6.

¹⁰⁵ Fletcher, 'The Courts and Euthanasia,' 226. On the basis of this conclusion a child abuser who takes his life after facing criminal charges would not be committing suicide.

¹⁰⁶ See cases discussed above, 93-94.

¹⁰⁷ See also Jarret, 1016-1018; Peters, 965-966.

¹⁰⁸ See above, 89-91.

¹⁰⁹ Sherlock, 557.

¹¹⁰ Fletcher, 'The Courts and Euthanasia,' 224-5. Under the ordinary principles of causation applying in the criminal law, the critical question is whether the death occurred at the time that it did as a result of the conduct of the defendant and it is irrelevant that the deceased's death was in any event imminent. See chapter I, 13-16.

¹¹¹ Fletcher, 'The Courts and Euthanasia,' 225.

purpose of bringing about his or her own death, the patient's conduct constitutes suicide.¹¹² Yet, even in these circumstances, the courts have maintained their position that refusal of treatment does not amount to suicide, relying on the argument that the patient's death is not self-initiated but results from 'natural causes'.¹¹³ This conclusion is clearly contrary to fact¹¹⁴ and highlights the distortions which have occurred in this area. It is difficult to deny that where a patient dies following the refusal of nutrition or hydration or other life-saving treatment of a minimally invasive nature, the patient's death is self-induced.¹¹⁵ Somewhat ironically, the logic of this conclusion has been accepted in the context of self-initiated starvation by prisoners, where arguably, it is least appropriate.¹¹⁶ In a number of cases involving hunger strikes by prisoners, the courts have held that the prisoners' conduct amounted to attempted suicide and therefore justified force-feeding.¹¹⁷ Yet, in analogous cases of patient's refusing treatment, including nutrition and hydration, the courts have avoided this conclusion. Clearly what the courts are doing is presenting as a factual premise, what is in reality a normative conclusion about how such conduct should be characterised.¹¹⁸

Whilst it may be more obvious in cases involving non-terminal patients, that a refusal of treatment may result in a self-induced death, the same reasoning applies with respect to terminal patients; any refusal of treatment which hastens death and which is deliberately made for this purpose amounts to suicide and should be recognised as such.

There are, undoubtedly, significant policy considerations which can be used to justify the view that refusals of treatment are to be distinguished from suicide. Although suicide is no longer illegal, there is still a stigma attached and the courts are understandably reluctant to classify as suicide, conduct which is socially acceptable. Furthermore, if some cases of refusal of treatment *are* held to be suicide, concerns are likely to arise about the legality of that conduct, both from the perspective of the patient and whether he or she is legally entitled to adopt that course without interference, and from the perspective of the doctor, whether compliance with a patient's request that treatment be discontinued amounts to assisting suicide. Nevertheless, the prevailing approach of creating fictions in order to avoid what in some cases are obvious conclusions is most undesirable and, in the long run, is likely to erode the credibility of the courts. Whilst the force of some of the underlying policy considerations must be acknowledged, there are more satisfactory means of dealing with these issues. It would be far

¹¹² Peters, 953-954; J. Bopp, 'Nutrition and Hydration for Patients: The Constitutional Aspects' (1988) 4 *Issues Law & Med.* 3, 47-48.

¹¹³ For example, *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986); *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986); *In re Rodas* District Court, County of Mesa, State of Colorado, No. 86 P.R. 139, 22 Jan. 1987.

¹¹⁴ Fletcher, 'The Courts and Euthanasia,' 225.

¹¹⁵ Matthews, 740; Cantor, *Legal Frontiers of Death and Dying*, 29, 51; Fisher, 247; Sherlock, 557. See also the dissenting judgments of Lynch and O'Connor J.J. in *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986) and the concurring judgment of Justice Scalia of the United States Supreme Court in *Cruzan v Director, Missouri Department of Health* 111 L. Ed. 2d 224, 251-156 (1990).

¹¹⁶ Lanham, 'The Right to Choose to Die with Dignity', 409.

¹¹⁷ For example, *In re Caulk* 480 A. 2d 93 (1984); *State ex. rel. White v Narick* 292 S.E. 2d 54 (1982); *Re Sanchez* 577 F.S. 7 (1983).

¹¹⁸ Jarret, 1017. See also the President's Commission Report, 68-9 for discussion regarding the normative content of causation determinations, based on assumptions about what is right or wrong under the circumstances.

preferable if the courts were to recognise that some cases of refusal of treatment *do* amount to suicide and then having recognised this as a starting point, to find more valid grounds to overcome the potential legal difficulties regarding the patient's right to pursue that course and the legal position of the doctor in assisting the patient.

The crux of the matter is that although in certain circumstances, refusal of treatment does amount to suicide, these cases are significantly different from other forms of suicide which the State may have a valid interest in preventing. It will therefore be argued that the competent patient's right to refuse treatment must be respected and upheld notwithstanding that it may be tantamount to suicide, and that doctors who assist patients in carrying out their suicidal intention by withholding or withdrawing treatment at the patient's direction, should be free of criminal liability.

Legal Implications of Recognising Refusal of Treatment as Suicide

It has been suggested in the foregoing pages that in many instances, the refusal of treatment by a patient is in fact tantamount to suicide and should be recognised as such. What then are the implications of this conclusion? Some commentators have accepted the analogy between refusal of treatment and suicide, but have argued that this logically demands that the same State interests which justify the prevention of suicide should apply to prevent the patient's refusal of treatment.¹¹⁹ This is by no means an inevitable conclusion; the question of whether refusal of treatment is legally tantamount to suicide is not determinative of whether the State can validly compel a patient to undergo treatment.¹²⁰

Although refusal of treatment may legally be equivalent to suicide, there are valid reasons for differentiating between the two.¹²¹ There is obviously no single explanation for the phenomenon of suicide, but there does appear to be widespread agreement that many suicide attempts are the products of mental disorder¹²² and not infrequently, represent a cry for help rather than a determined effort to die.¹²³ If the persons attempting to commit suicide are restrained and given assistance, the majority

¹¹⁹ For example, Hegland, 869-871; Cantor, 'A Patient's Decision to Decline Life-Saving Treatment: Bodily Integrity Versus the Preservation of Life', 255, n. 135; Note, 'Compulsory Medical Treatment and Constitutional Guarantee: A Conflict?' (1972) 33 *U.Pitt.L.Rev.* 628, 634. Note also *John F. Kennedy Memorial Hospital v Heston* 58 N.J. 576, 581-582 (1971) cited above, 93.

¹²⁰ Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,' 255.

¹²¹ M. Heifetz with C. Mangel, *The Right to Die* (1975) 79-81; T. Engelhardt, *The Foundations of Bioethics* (1986) 315; Peters, 966-970; Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,' 256-257. In addition to the argument based upon rational as opposed to irrational death Cantor suggests that the sheer magnitude of the suicide problem justifies government intervention and differentiates common suicide from the refusal of treatment cases.

¹²² Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,' 256; Williams, 616-617; Engelhardt, 315.

¹²³ Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,' 256.

do not make a further attempt.¹²⁴ It is therefore perfectly valid for the State to intervene to prevent the occurrence of suicide as a general rule, since the State has a valid interest in the prevention of irrational self-destruction.¹²⁵ The State's concern in relation to suicide is reflected in the continued legal regulation of some aspects of suicide; although suicide is no longer punishable, aiding or assisting suicide remains a crime and in some jurisdictions the law permits a person to use reasonable force to prevent suicide.¹²⁶

As a general proposition, State intervention to prevent suicide is justifiable, however, special considerations apply in relation to those suicides which take the form of a refusal of medical treatment. For terminal patients, the choice of death may be a rational one, offering a release from a painful and undignified death.¹²⁷ Even where a patient's condition is non-terminal, the patient may be suffering acutely from a debilitated and dependent existence and life on such terms may become unacceptable to the patient. Here again, the choice of death may be entirely rational. In the medical context, the refusal of treatment by a patient is usually a considered and rational decision, based on their medical condition and the circumstances of their continued existence.¹²⁸ The State's legitimate interest in the prevention of irrational self-destruction clearly does not arise in these circumstances.¹²⁹

Thus, there is an important distinction to be made between the usual type of suicide and refusal of treatment by a patient aimed at facilitating an earlier death. However, the courts in the United States have adopted an inappropriate means of giving effect to this distinction. As we have seen, the courts have consistently denied the connection between suicide and refusal of treatment and have thereby been able to avoid consideration of the State's interest in the prevention of suicide in such cases. In this way, the courts have upheld the right of a patient to refuse treatment even though that refusal closely approximates suicide. It was argued earlier that this line of reasoning is deficient, resulting in unnecessary distortions of fact and law.¹³⁰ In its place, an alternative model is suggested; we need to recognise that refusal of treatment may amount to suicide, but must tailor our response to this

¹²⁴ P. Skegg, 'A Justification for Medical Procedures Performed Without Consent' (1974) 90 *Law Q.Rev.* 512, 524 where he cites E. Stengel and N.G. Cook, *Attempted Suicide* (1958) 19-24, 126-127, 129 and E. Stengel, *Suicide and Attempted Suicide* (1964) 79-84.

¹²⁵ *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 425 (1977); *Bartling v Superior Court* 163 Cal. App. 3d 186, 209 (1984). M.D.

¹²⁶ For example, A.C.T. s. 18 *Crimes (Amendment) Ordinance (No. 2)* 1990; Vic. s. 463B *Crimes Act* 1958; N.S.W. s. 574B *Crimes Act* 1900; S.A. s. 13(a)(2) *Criminal Law Consolidation Act* 1935 as amended by the *Criminal Law Consolidation Act Amendment Act* 1983. Note also s. 155 of the Northern Territory *Criminal Code* 1983 dealing with liability for failure to rescue which may arguably impose a duty to prevent suicide.

¹²⁷ For support for the view that patient suicide may be rational, see S. Wanzer *et al.*, 'The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look' (1989) 320 *New Eng.J.Med.* 844, 847-848; R. Brandt, 'The Rationality of Suicide' in M. Battin and D. Mayo, (eds.) *Suicide* (1980) 117.

¹²⁸ It is, of course, possible that a patient may have suicidal intentions, quite unrelated to the medical condition which requires life-saving medical treatment; see Lanham, 'The Right to Choose to Die with Dignity,' 410.

¹²⁹ The comments of the court in *Superintendent of Belchertown State School v Saikewicz* 370 N.E. 2d 417, 426 n. 11 (1977) are particularly apt in this context. It was stated that 'the underlying State interest in this area lies in the preservation of self-destruction. What we are considering here is a competent rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.' M.D.

¹³⁰ See above, 95-99.

particular form of suicide so as to take into account the special considerations applying in the medical context. Thus, having regard to the circumstances of the patient and the overriding principle of self-determination,¹³¹ it will be readily apparent that any interest the State may have in the prevention of irrational suicide simply does not apply in such cases.¹³² Conversely, because of the special features of the refusal of treatment cases, upholding a patient's right to refuse treatment (even though that refusal may be tantamount to suicide), does not necessarily imply a *general* right to commit suicide free of State intervention.¹³³

In the foregoing analysis, it has been argued that the refusal of treatment by a patient may be tantamount to suicide. On the assumption that this proposition is indeed correct,¹³⁴ it becomes necessary to consider the legal implications of this conclusion for the medical profession. In particular, it is necessary to examine whether a doctor's compliance with the patient's request amounts to the criminal offence of assisting suicide and whether a doctor has a legal right, or indeed, an obligation, to prevent the patient from committing suicide in this way.

Does a Doctor's Compliance with a Patient's Refusal of Treatment Amount to Assisting Suicide?¹³⁵

This is a question of some considerable importance; if a doctor could incur criminal liability for assisting suicide as a result of his or her acquiescence in the patient's refusal of treatment, it would have the effect of seriously undermining the common law right to refuse treatment. This has already proved to be a matter of practical relevance; in a number of the refusal of treatment cases litigated in the United States, the hospital and medical staff refused to comply with the patient's request on the ground that to do so would involve them in liability for assisting suicide.¹³⁶

In order to ascertain whether a doctor's compliance with the patient's refusal of treatment can amount to assisting suicide, it is necessary to examine the legal requirements in respect of assisting suicide and the case law in this area. It will be argued that if the statutory prohibitions regarding assisted suicide are given a fairly wide interpretation, the conduct of a doctor in acquiescing in the patient's refusal of treatment could theoretically attract criminal liability. Whilst this is obviously an

¹³¹ Cantor, *Legal Frontiers of Death and Dying*, 50-51.

¹³² This conclusion will almost inevitably flow in circumstances where the patient's condition is terminal or where the patient is suffering from a debilitating and irreversible condition. Where, however, the patient is potentially salvageable to a healthy existence, the position is less clear; arguably, the State interest in the prevention of suicide is stronger in these circumstances but faithful adherence to the principle of self-determination would protect the right of a patient to refuse treatment in such cases.

¹³³ Engelhardt, 315. But see Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,' 258 where he argues that if we uphold refusals of treatment which are suicidal, we must permit all cases of 'serious suicide'; i.e., persons whose decision to die is clearly competent, deliberate and firm should be permitted to die.

¹³⁴ Even if this was *not* accepted as a general proposition, it is nevertheless possible to envisage circumstances in which the refusal of treatment by a patient would be regarded by most people as tantamount to suicide; e.g. a quadriplegic, non-terminal patient who decides to starve himself to death.

¹³⁵ Although this analysis is confined to consideration of the potential liability of doctors, it should be noted that the relatives of a patient could also potentially be liable for assisting the suicide of a patient by their compliance with a patient's refusal of treatment.

¹³⁶ *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986); *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986).

undesirable possibility, the laws in relation to the prevention of suicide have a sound social purpose and it would therefore be inappropriate to distort the meaning of these terms in order to protect doctors from liability. The better solution to this difficulty is found through the patient's common law right to refuse treatment and reliance upon an argument analogous to that raised earlier in the context of homicide.¹³⁷ The essence of this argument, applied here to the issue of suicide, is that since a doctor is legally required to respect the directions of a patient who has decision-making capacity, a doctor's compliance with a patient's refusal of treatment cannot constitute the criminal offence of assisting suicide, even though the patient's refusal of treatment may be tantamount to suicide and the doctor does in fact provide assistance to the patient.

Can the Offence of Assisting Suicide be Established on the Basis of *Passive Conduct*?

As was outlined earlier, although suicide is no longer an offence in any of the Australian jurisdictions, a new statutory offence of assisting suicide has been created, pursuant to which, a person is variously prohibited from aiding, abetting, instigating, counselling or procuring the suicide of another.¹³⁸ Since the conduct under consideration is essentially of a passive nature (i.e. the withdrawal or withholding of treatment by a doctor at the request of a patient)¹³⁹ a preliminary matter for determination is whether it is possible to aid or abet by omission or whether something in the nature of affirmative conduct is required.

In the jurisdictions under consideration, the only case to specifically consider this matter in the context of determining the legal liability of a doctor for assisting the suicide of his or her patient as a result of withholding or withdrawing treatment, has arisen in the United States.¹⁴⁰ In the case of *Bouvia v Superior Court*¹⁴¹ the hospital and treating doctors had argued that Elizabeth Bouvia should not be allowed to refuse medical treatment whilst in their care because that would be tantamount to suicide and they could accordingly be liable for aiding and abetting suicide.¹⁴² The court was therefore called upon to consider the possible liability of the hospital and medical staff for assisting Bouvia's suicide.¹⁴³ At first instance, it was held that Bouvia was committing suicide by her refusal of

¹³⁷ See chapter II, 70-82.

¹³⁸ See above, 83-84.

¹³⁹ It will be argued in the following chapter that some cases of withdrawal of treatment involve affirmative conduct, such as turning off artificial life-support or the withdrawal of artificial nutrition and hydration. (For discussion, see chapter IV, 150-163.) These forms of withdrawal of treatment have nevertheless usually been classified as omissions rather than acts.

¹⁴⁰ In the case of *Nancy B. v Hotel-Dieu de Quebec et al* 69 C.C.C. (3d) (1992) 450 (see chapter II, 78-79) the Quebec Superior Court held that persons involved in the termination of artificial life-support to the patient in order to permit nature to take its course, would not be aiding the suicide of the patient in contravention of s. 241 of the Canadian *Criminal Code* 1985. This conclusion appears to have been based on the court's view that if the death of the patient occurred after the respiratory support treatment had been stopped at the patient's request, it would be because nature had taken its course and would consequently be distinguishable from suicide which is not a natural death. (460) Consequently, the court did not specifically consider whether it was possible to aid suicide by omission.

¹⁴¹ 225 Cal. Rptr. 297 (1986).

¹⁴² *Id.* 306. Furthermore, it was argued that since the patient was in a public facility, the State would be a party to her conduct and the State could not be forced to commit the crime of aiding and abetting suicide.

¹⁴³ The law in relation to assisting suicide in the State of California is contained in s. 401 of the Californian *Penal Code* which states that 'every person who deliberately aids, or advises, or encourages another to commit suicide is guilty of a felony.'

treatment and the medical staff would be assisting her suicide if they adhered to her request that she not be force-fed.¹⁴⁴ On appeal, however, this ruling was overturned and it was held that by refusing treatment, Bouvia was not committing suicide, but simply letting nature take its course.¹⁴⁵ This conclusion would have been enough to dispose of the suggestion that the hospital and medical staff might have been liable for assisting suicide. Nevertheless, the court went on to consider the possible criminal liability of the hospital and medical staff. The Court of Appeal was of the view that to establish liability for aiding or abetting suicide, there must be some affirmative act such as providing a gun, poison, knife or other instrumentality by which a person could inflict upon themselves an immediate and fatal injury.¹⁴⁶ Such situations were said to be 'far different than the mere presence of a doctor during the exercise of [a] patient's constitutional rights.'¹⁴⁷ Thus, the appellate court was able to conclude that neither the doctors nor the hospital would be criminally liable for assisting suicide if they were to respect the decision of a competent and informed patient to refuse medical treatment.

On the basis of the *Bouvia* case it would appear that in order to establish liability for assisting suicide, there must be some affirmative conduct on the part of the accused, such as supplying the means for taking one's life, and conduct in the nature of an omission to act would not suffice.¹⁴⁸ On this reasoning, a doctor's compliance with the refusal of treatment by a patient, with decision-making capacity, would not attract criminal liability for assisting suicide. However, it may be wondered to what extent this reasoning has been influenced by policy considerations and in particular, the natural reluctance of the courts to impose criminal liability on doctors.

There seems to be no reason in principle why the offence of assisting suicide cannot be committed by omission, provided it is accompanied by the necessary intent. This conclusion is supported by an analysis of the wording used in the various statutory prohibitions on assisting suicide. The word 'aid'¹⁴⁹ has been defined as meaning 'to help or assist'¹⁵⁰ and it is certainly possible to envisage circumstances in which a person may, in a general sense, aid another in committing suicide, although not actually taking an active role in the person's suicide; for example, acting as lookout to clear the way for the person to commit suicide, or the deliberate failure to seek medical assistance for a person who has attempted to commit suicide with the intention of facilitating that suicide.¹⁵¹ This

¹⁴⁴ *Id.* 305-306.

¹⁴⁵ *Id.* 306.

¹⁴⁶ *Ibid.* See also *In re Joseph G.* 34 Cal. 3d 429, 436 (1983).

¹⁴⁷ 225 Cal Rptr. 297, 306 (1986).

¹⁴⁸ This view is also supported by some commentators; see, for example, Williams, 613.

¹⁴⁹ This term is used in the legislation of most jurisdictions; see A.C.T. s. 17(1) *Crimes (Amendment) Ordinance (No. 2)* 1990; N.S.W. s. 31C(1) *Crimes Act* 1900 as amended by the *Crimes (Mental Disorder) Amendment Act* 1983; S.A. s. 13(a)(5), *Criminal Law Consolidation Act* 1935 as amended by the *Criminal Law Consolidation Act Amendment Act* 1983; Vic. s. 6B(2)(b) of the *Crimes Act* 1958; and in the Code jurisdictions, N.T. s. 168(c); Qld. s. 311(3); Tas. s. 163; W.A. s. 288(3). Note also s. 241 of the Canadian *Criminal Code* 1985; s. 179 of the New Zealand *Crimes Act* 1961.

¹⁵⁰ *R v Arnol* [1981] Tas.R. 157 per Everett J. at 230 (in the context of parties to offences); *Attorney-General v Able* [1984] 1 All E.R. 277.

¹⁵¹ In an English case, *R v Johnson* (unreported) the parents of a girl who had committed suicide after a long period of disablement from multiple sclerosis were convicted of aiding and abetting the suicide of their daughter because of their failure to intervene to prevent her suicide; Note, 'Wrong to do Right'

interpretation of aiding suicide has the advantage of consistency with the general criminal law principles regarding complicity in crime. For the purposes of those jurisdictions which prohibit abetting suicide,¹⁵² it is evident from judicial interpretation of the word 'abet' in the context of parties to offences that there is no requirement of active conduct or assistance; abetment can be established merely on the basis of a person's presence and acquiescence in certain conduct, where, by their presence, the person intended to and did in fact give encouragement.¹⁵³ In any event, in a typical refusal of treatment case, the withholding or withdrawing of life-saving medical treatment would be accompanied by continued medical and physical comfort care from doctors and nursing staff which could readily be interpreted as active assistance or encouragement of the patient in their effort to commit suicide. Even in the absence of such active assistance, it is possible that the existence of the doctor/patient relationship, which imposes on doctors certain duties with regard to their patients, may be a factor influencing a court to find that the passive conduct of a doctor did amount to assistance.

There have, to date, been no reported cases in Australia directly raising the question of a doctor's potential liability for assisting suicide as a result of his or her withholding or withdrawing treatment at the request of the patient. However, an interesting case which may shed some light on this issue is the decision of Justice Fullagar of the Victorian Supreme Court in *Re Kinney*.¹⁵⁴ This case involved an unsuccessful suicide attempt by Mr Kinney who was suffering from leukemia and awaiting trial on a murder charge. As a result of an attempted suicide by drug overdose, the patient was in urgent need of medical treatment. The patient's wife, sought an injunction to stop St. Vincent's Hospital from treating her husband and gave evidence that her husband had indicated to her that he wanted to die. Justice Fullagar refused to grant the injunction sought, stating that:

The preventing of medical or surgical treatment amounts to carrying into execution the attempted suicide of the person concerned. *To grant the injunction would be to assist the person to complete his suicide.*¹⁵⁵

This decision could be interpreted as supporting the proposition that suicide assistance can take the form of an omission; the injunction was sought to prevent treatment, and the court held that granting the injunction would be to assist the person in his suicide, the clear implication being that withholding or withdrawing treatment can amount to assisting suicide.

(1990) 38 *V.E.S. Newsletter* 1. The case appears to support the proposition that the offence of assisting suicide can be committed by passive conduct which in some way facilitates the person's suicide.

¹⁵² A.C.T. s. 17(1) *Crimes (Amendment) Ordinance (No. 2)* 1990; N.S.W. s. 31C(1) of the *Crimes Act* 1900 as amended by the *Crimes (Mental Disorder) Amendment Act* 1983; S.A. s. 13(a)(5) *Criminal Law Consolidation Act* 1935 as amended by the *Criminal Law Consolidation Act Amendment Act* 1983; Vic. s. 6B(2)(b) of the *Crimes Act* 1958. Note also s. 241(b) of the Canadian *Criminal Code* 1985; s. 179(b) of the New Zealand *Crimes Act* 1961.

¹⁵³ *R v Russel* [1933] V.R. 59, 66-67; *R v Clarkson* (1971) 55 *Crim.App.R.* 445, 448.

¹⁵⁴ (Unreported) 23 Dec. 1988, S.C. Vic. See also discussion of this case by L. Skene, 'The Fullagar Judgment' (1989) 14 *L.S.B.* 42; Mendelson, 37-38; and N. Tonti-Filippini, 'Some Refusals of Medical Treatment Which Have Changed the Law in Victoria' (1992) 157 *M.J.A.* 277, 278-279.

¹⁵⁵ *Id.* 4. (Author's emphasis.)

Another first instance decision along similar lines was made in the case of *Schneidas v Corrective Services Commission*¹⁵⁶ considered earlier,¹⁵⁷ which involved the force-feeding of a prisoner on a hunger strike. In an application brought on behalf of the prisoner to prevent the prison authorities from force-feeding him, Lee J. refused to grant the injunction since it would in effect aid and abet the prisoner in committing suicide.¹⁵⁸ By analogy, it could therefore be argued that a doctor who withholds or withdraws treatment at the request of a patient pursuant to a patient's suicidal refusal of treatment, in effect assists (aids, abets etc.) the patient in committing suicide.

Since neither of these cases specifically dealt with the question of liability for assisting suicide as a result of passive conduct, such as a doctor's compliance with the patient's suicidal refusal of treatment, one must be careful not to overstate the significance of these decisions. Nevertheless, the cases can be interpreted in support of the view that the offence of assisting suicide could be established on the basis of some relevant omission as distinct from affirmative conduct.

Reference was made earlier to the English case of *Attorney-General v Able*¹⁵⁹ in which Justice Woolf was called upon to interpret the English provision dealing with suicide assistance. Whilst this case did not specifically consider whether the offence of assisting suicide can be committed by omission, the principles laid down in that case¹⁶⁰ may nevertheless provide some guidance in interpreting the prohibition on assisting suicide and assessing whether a doctor may be acting unlawfully by complying with a patient's refusal of treatment. If it is accepted that the refusal of treatment by a patient may be equivalent to suicide and that the offence of assisting suicide can be established on the basis of passive conduct, it could be argued on the basis of the reasoning in *Attorney-General v Able*, that in some circumstances at least, doctors who withhold or withdraw treatment intend to assist the patient to commit suicide, by their inaction, provide assistance, and the patient is thereby in fact assisted in committing suicide. Thus, the various requirements for the commission of the offence of assisting suicide could arguably be satisfied.¹⁶¹ According to Woolf J. in *Attorney-General v Able*, if these elements can be proved, it does not make any difference that the person would have committed suicide anyway.¹⁶²

It would appear from the foregoing analysis that as a matter of interpretation, the conduct of a doctor in complying with the patient's suicidal refusal of treatment could potentially come within the

¹⁵⁶ (Unreported) 8 April 1983, S.C. N.S.W.

¹⁵⁷ See above, 90-91.

¹⁵⁸ As noted earlier, (above, n. 57) at the time of this decision, suicide was still a crime in New South Wales.

¹⁵⁹ [1984] 1 All E.R. 277. See above, 85-87.

¹⁶⁰ See above, 86.

¹⁶¹ Probably the most difficult element to establish would be that the doctor *intended* to assist the patient's suicide; it could for example be argued that a doctor who withholds or withdraws treatment on a patient's instructions simply seeks to honour the patient's refusal and does not intend to assist the patient's suicide. It should be noted, however, that Woolf J. in *Attorney-General v Able* [1984] 1 All E.R. 277 held that an intention to assist a person commit suicide need not involve a desire that suicide should be committed or attempted; see above, 86.

¹⁶² [1984] 1 All E.R. 277, 288.

prohibition on assisting suicide. It therefore becomes very relevant to examine the legal effect of a patient's right to refuse treatment on the doctor's potential criminal liability.

Legal Effect of a Patient's Right to Refuse Treatment upon a Doctor's Potential Liability for Assisting Suicide

As outlined in the preceding chapter, the common law principles of informed consent and self-determination prohibit any unauthorised medical intervention except in emergency cases where the patient's consent cannot be obtained.¹⁶³ Thus, if a patient, who has decision-making capacity, refuses further medical treatment, the doctor is legally obliged to respect the patient's decision and the failure to do so may attract both criminal and civil liability.¹⁶⁴ Since the doctor cannot continue to treat the patient except with the patient's consent, the doctor cannot be held criminally liable for assisting suicide where he or she simply respects the patient's wishes and withholds or withdraws treatment.¹⁶⁵ As a matter of both law and logic, it cannot be unlawful to do that which by law one is legally required to do.¹⁶⁶ The most satisfactory way in which the legal principles regarding liability for assisted suicide and the refusal of treatment can be reconciled is for the courts to take a broad view of the patient's right to refuse treatment so that the withholding or withdrawal of treatment performed in recognition of that right is exempt from criminal liability even though the requirements for a doctor's liability for assisting suicide may be present.¹⁶⁷ Whilst this line of reasoning has yet to be unequivocally confirmed by the courts, some support for this view can be gleaned from a number of cases decided in the United States dealing with the constitutional right of privacy.¹⁶⁸ Although rights which are constitutionally guaranteed obviously have a special status, in view of the similarities between the common law right to refuse treatment and the equivalent constitutional guarantee, there is some foundation for the adoption of analogous arguments with respect to protection from criminal liability for those who assist a patient in the exercise of his or her common law right to refuse treatment. This is of particular relevance in jurisdictions such as Australia and the United Kingdom,

¹⁶³ See chapter II, 40-41.

¹⁶⁴ See chapter II, 34.

¹⁶⁵ D. Meyers, *Medico Legal Implications of Death and Dying* (1981) 134-5; Williams, 613.

¹⁶⁶ The defence of necessity may be relevant in this context on the basis that since there is a legal duty to comply with the patient's wishes there can be no criminal liability for doing so. (See chapter II, n. 280.) Of particular relevance is the Canadian case of *Perka v R* (1985) 14 C.C.C. 3d 385, 417-420 which specifically recognises the existence of the defence of necessity in circumstances where the defendant is faced with conflicting legal duties.

¹⁶⁷ I.e., that the patient by his or her refusal of treatment is committing suicide, that the doctor intends to assist the patient and does in fact assist the patient in committing suicide.

¹⁶⁸ *In re Quinlan* 355 A. 2d 647 (1976) (in which the court held that the exercise of the patient's constitutional right of privacy is protected from criminal prosecutions and that this protection extends to third parties whose action was necessary to effectuate the exercise of that right); *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986) (in which the court distinguished between circumstances involving affirmative acts, such as providing the means for the person to commit suicide and 'the mere presence of a doctor during the exercise of [a] patient's constitutional rights.' Some commentators in the United States have even gone so far as to suggest that the constitutional right of privacy recognised in many cases encompasses a right to commit suicide. For discussion, see L. Carl, 'The Right to Voluntary Euthanasia' (1988) 10 *Whittier L.Rev.* 489, 494-497. However, in light of the United States Supreme Court decision in the *Cruzan* case (111 L. Ed. 2d 224 (1990)) where it was held that refusal of treatment by a patient should be analysed in terms of a Fourteenth Amendment liberty interest rather than the more generalised constitutional right of privacy (see chapter II, 47) such claims appear to be without foundation.

where there is fairly widespread acceptance of the right of a patient to refuse treatment, but no equivalent constitutional right.

In the foregoing pages, attention has been focussed on the potential legal liability for assisting suicide of a doctor who, in compliance with the suicidal request of a patient, with decision-making capacity, withholds or withdraws treatment. A distinct, but nevertheless related matter is whether a doctor ever has the right to intervene so as to prevent the patient from committing suicide or is even under a duty to do so.

Does a Doctor Have a Right or Indeed a Duty to Prevent Suicide?

At one time, suicide and attempted suicide were crimes and it was therefore possible to justify intervention in a person's attempted suicide in order to prevent the commission of a crime.¹⁶⁹ Since suicide has ceased to be criminal under Australian law this particular argument no longer applies. Although suicide is no longer a criminal offence, as noted earlier, in a number of Australian jurisdictions legislation exists which permits the use of reasonable force to prevent a person from committing suicide.¹⁷⁰ Even in jurisdictions where there is no such provision, it could be argued on policy grounds that well-intentioned intervention in an attempted suicide should not give rise to civil or criminal liability.¹⁷¹

It has, for example, been argued that where a patient refuses treatment in the knowledge that death will result, the doctor is under an obligation to ignore the patient's request and, under the protection of the plea of necessity, prevent the patient, from adopting a course of conduct which would lead to self-destruction.¹⁷² Reliance may be placed on the *Leigh v Gladstone*¹⁷³ case in support of this view.¹⁷⁴ Whilst the principle in that case is potentially wide and may well be capable of extension to the medical context, commentators have overwhelmingly rejected such an approach.¹⁷⁵ Kennedy¹⁷⁶ for example, suggests that the case was simply a response to 'a particular situation against a particular political background, and is poor material on which to build any general proposition'. The consensus appears to be that reliance upon this authority so as to provide justification to a doctor to override a

¹⁶⁹ Williams, 616-617. It should be noted that attempted suicide remains a crime in the Northern Territory; s. 169 *Criminal Code* 1983 (N.T.).

¹⁷⁰ See above, 100.

¹⁷¹ See D. Kloss, 'Consent to Medical Treatment' (1965) 5 *Med. Science & Law* 89, 91-92 and the case of *Meyer v Supreme Lodge Knights of Pythias* 70 N.E. 111 (1904) in which it was held by a majority of the New York Court of Appeal that a doctor who gave medical treatment to an attempted suicide, contrary to that person's express wishes, would not be liable in trespass. But as Zellick points out at 166, since the facts of this case involved irrational, impulsive suicide, the case is not authority for the broad proposition that all intervention in suicide is protected from liability. In circumstances where a well meaning person intervenes to prevent a suicide, even if such conduct is technically unlawful, it would be most unlikely to give rise to prosecutions and if prosecuted, the persons would almost certainly be given an absolute discharge; Williams, 617.

¹⁷² Kennedy, 226-7 where he cites J.C. Smith and B. Hogan, *Criminal Law* (3rd ed., 1973) 158. This point does not, however, appear to have been made in subsequent editions of this text.

¹⁷³ (1909) 26 T.L.R. 139.

¹⁷⁴ The court upheld the forced feeding of a suffragette prisoner by the prison authorities and suggested that the prison officers may in fact have been under a duty to preserve the prisoner's life; see above, 90.

¹⁷⁵ Kennedy, 227; Zellick, 171; Skegg, 525-6.

¹⁷⁶ 'The Legal Effect of Requests by the Terminally Ill and the Aged Not to Receive Further Treatment from Doctors,' 227.

patient's refusal of treatment would be a most inappropriate infringement of the patient's right of self-determination.¹⁷⁷ Thus, *Leigh v Gladstone* cannot validly be used to impose upon doctors a *duty* or for that matter even a *right* to prevent a patient from committing suicide by refusing treatment. As was argued in the preceding chapter,¹⁷⁸ the defence of necessity should only apply in emergency situations where the patient is in need of life-saving treatment but the patient's consent to that treatment cannot be obtained. It does not justify overriding the refusal of treatment by a patient, who has decision-making capacity, even where that refusal is clearly suicidal.

A related line of argument that may be advanced is that a doctor is not obliged to respect a suicidal request by a patient that treatment be terminated, indeed that he or she is obliged to disregard it, since otherwise the doctor would be criminally liable for the offence of assisting suicide.¹⁷⁹ It has been argued that the conduct of a doctor in complying with a patient's suicidal refusal of treatment does, strictly speaking, come within the statutory prohibition on assisting suicide. However, as outlined earlier, patients who have decision-making capacity have the right to refuse treatment and a doctor may in fact incur both civil and criminal liability for disregarding the patients' directions.¹⁸⁰ It follows therefore that a doctor should be protected from any criminal liability which may arise as a result of the doctor respecting the patient's refusal of treatment. Thus, it would not be legally justifiable for a doctor to force treatment upon a patient on the grounds that it is necessary to do so in order to avoid liability for assisting suicide.

Rational Suicide by a Patient Distinguished from Irrational Suicide - A Reconciliation with State Suicide Policy

Although as a general proposition, doctors are sometimes free and indeed, even obliged to intervene to avert the consequences of suicide attempts,¹⁸¹ a doctor is under no legal duty to prevent the rational suicide of a patient with decision-making capacity, who has declined life-saving treatment. Furthermore, it is questionable whether a doctor has a legal right to intervene in these circumstances.

¹⁷⁷ *Ibid.*; Zellick, 171; Skegg, 526.

¹⁷⁸ Chapter II, 40-41.

¹⁷⁹ Kennedy, 226-228.

¹⁸⁰ See above, 34.

¹⁸¹ For discussion, see Giesen, 358; Skegg, *Law, Ethics and Medicine*, 110-113. When suicide was an offence a doctor's intervention could be justified on the basis of preventing the commission of a crime. However, since the abolition of the crime of suicide it has continued to be accepted that doctors are sometimes free, and may even be under a duty, to prevent a person from committing suicide. Once the relationship of doctor/patient is established, a doctor is under an affirmative duty of care to the patient. The failure by a doctor to administer necessary medical treatment to a person who has attempted to commit suicide may result in criminal prosecution for manslaughter on the grounds of criminal negligence and/or civil proceedings for negligence; e.g. *Selfe v King George Hospital* (unreported) *The Times* 26 Nov. 1970. Particularly where the doctor or hospital knows, or ought to know of the risk of suicide, the health care providers would be under a special duty to supervise the patient, especially in psychiatric health care institutions. For other cases suggesting that doctors are sometimes under a duty to prevent patients from committing suicide, see *Pallister v Waikato Hospital* [1975] N.Z.L.R. 725, 736, 741-748; *Haines v Bellissimo* (1977) 82 D.L.R. 3d 215. Cf. *Robson v Ashworth* (1985) 33 C.C.L.T. 229, 246-24 in which the Ontario High Court dismissed a negligence action on public policy grounds since the concept of a sane suicide's responsibility for his or her own actions militated conclusively against liability of others.

The State has a legitimate interest in the prevention of suicide. As was previously observed, suicide is frequently associated with mental disorder and irrational behaviour and in many instances, attempted suicides represent a plea for help rather than a determined effort to die.¹⁸² Accordingly, laws which are directed to the prevention of suicide¹⁸³ are perfectly sound and serve an important social service in protecting individuals from irrational self-destruction.

It is imperative, however, to distinguish between two fundamentally different types of suicide; the typical form of suicide or attempted suicide which is the product of irrational and disturbed behaviour on the one hand and on the other, the situation where a person, who has decision-making capacity, reaches a reasoned and firm decision that he or she wishes to die. For the purposes of the present discussion, the prime example of rational suicide is where a patient reaches a decision to end his or her life and in furtherance of that decision, seeks to commit suicide, either by refusing necessary medical treatment or by some other means.¹⁸⁴

Since society has a legitimate interest in the prevention of irrational self-destruction, nothing should impede well meaning by-standers or medical staff from intervening in clear cases of irrational suicide and imposing medical treatment in an attempt to save the life of that person. Further, where a person is found attempting to commit suicide, and nothing is known about his or her state of mind, it would be reasonable to assume that the attempt is evidence of mental disorder¹⁸⁵ and it would be quite justifiable for concerned persons or members of the medical profession to take whatever steps were necessary to prevent the death of that person. As Skegg points out, doctors are constantly intervening in these circumstances and there can be little doubt that a court would hold their action to be justified.¹⁸⁶

Where, however, there is clear evidence that a patient, who has decision-making capacity, has made a well informed, firm and rational decision that they wish to die, and elects to commit suicide, the decision of the patient should be upheld.¹⁸⁷ In these circumstances, it would be completely inappropriate and misplaced for medical staff to impose medical treatment against the wishes of the patient, on the grounds that they are preventing the patient's suicide. This conclusion has been endorsed by a group of prominent American doctors in the United States. In an influential paper, it was accepted that if a terminal patient, not suffering from treatable depression, acts on his or her wish

¹⁸² See above, 99 and Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,' 256.

¹⁸³ For example, the general prohibition on assisting suicide and the provisions which exist permitting physical intervention in order to prevent a person from committing suicide. See above, 100.

¹⁸⁴ For support for the view that patient suicide may be rational, see above, n. 127.

¹⁸⁵ The available empirical evidence supports the presumption of unsoundness of mind. See also Williams, 616.

¹⁸⁶ Skegg, 'A Justification for Medical Procedures Performed Without Consent,' 525. See also G. Williams, *The Sanctity of Life and the Criminal Law* (1956) 292.

¹⁸⁷ Cantor, *Legal Frontiers of Death and Dying*, 50-51; Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,' 258; Williams, *Textbook of Criminal Law*, 617; Skegg, 'A Justification for Medical Procedures Performed Without Consent,' 524.

for death and commits suicide, it is ethical for a doctor who knows the patient well to refrain from an attempt at resuscitation.¹⁸⁸

Legal validation for the foregoing view can be found in the fundamental common law right of a patient, who has decision-making capacity, to refuse medical treatment. Provided there is clear evidence of a firm and informed decision by the patient, the doctor has no right to intervene in the patient's suicide.¹⁸⁹ Further, the validity of the patient's decision to commit suicide should not be dependent on whether the patient's condition is terminal. Whilst it may, from an objective point of view, be easier to understand the decision of a terminal patient to put and end to prolonged suffering and opt for an earlier death, the decision of a salvageable patient to commit suicide may also be perfectly rational. It is a fundamental aspect of an individual's right to bodily integrity and self-determination, that he or she should be free to make his or her own assessment of quality of life and determine when continued existence becomes an intolerable burden.¹⁹⁰ Provided the patient has decision-making capacity and the patient's decision is fully informed it should be respected by the medical staff.¹⁹¹

Once one accepts that a patient's decision to commit suicide (whether by refusal of treatment or other means) should be upheld if it is the product of a reasoned and rational decision, it must be recognised that these arguments carry implications far beyond the medical context. As Cantor has correctly pointed out, if these arguments are taken to their logical conclusion, it would require that all serious suicides, (i.e. of persons who have decision-making capacity and whose decision is deliberate and firm) should be permitted to die and medical intervention to prevent such suicides would be unwarranted.¹⁹² Although a full examination of these wider issues is beyond the scope of this thesis, it should be noted that many commentators have acknowledged the possibility of rational suicide.¹⁹³ In circumstances where the suicide is rational, it could be argued that the State interest in the prevention of suicide in the form of irrational self-destruction does not arise.¹⁹⁴

¹⁸⁸ Wanzer *et al*, 'The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look', 848. Ten of the twelve doctors expressed their belief that it is not immoral for a doctor to assist in the rational suicide of a terminally ill person by, for example, prescribing drugs.

¹⁸⁹ This should be the case even in those jurisdictions which have specific statutory provision allowing the use of force to prevent suicide. Since the object of these provisions is to prevent *irrational* self-destruction it would be indefensible to invoke these powers in circumstances where it is known that the patient has made a clear and rational decision to commit suicide.

¹⁹⁰ Cantor, *Legal Frontiers of Death and Dying*, 51.

¹⁹¹ See chapter II, 42-43 for discussion regarding assessment of the patient's competence and capacity for rational decision-making.

¹⁹² Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life', 258; Cantor, *Legal Frontiers of Death and Dying*, 51-52; Zellick, 170-1; Skegg, 'A Justification for Medical Procedures Performed Without Consent', 524.

¹⁹³ See above, n. 127.

¹⁹⁴ Cantor, *Legal Frontiers of Death and Dying*, 52.

Conclusion

The object of this chapter has been to examine the law in relation to assisted suicide and to consider the potential criminal liability of a doctor who assists a patient to die. If a doctor actively assists a patient in committing suicide, for example, by supplying the necessary means to bring about the patient's death, the doctor may be criminally liable for assisting suicide. However, by non-action, a doctor may lawfully facilitate the suicide of a patient who wished to hasten his or her death by refusing treatment. Although refusal of treatment may in certain circumstances constitute suicide, it has been argued that since a patient has a common law right to refuse treatment, a doctor is legally required to comply with the patient's refusal and would therefore not be criminally liable for respecting the patient's decision. Further, it has been suggested that the legitimate State aim of suicide prevention does not justify intervention in the rational suicide by a patient who has decision-making capacity. A doctor is under no duty to intervene so as to avert this form of suicide and arguably has no right to prevent the patient's exercise of self-determination.

On the basis of the analysis in the foregoing chapters, it can be concluded that patients have a right to refuse medical treatment, including life-saving medical treatment, and a doctor who assists a patient to die by either withholding or withdrawing treatment would not incur criminal liability for either homicide or assisted suicide. There is, therefore, some scope for the lawful practice of passive euthanasia. If, however, a doctor takes active steps in assisting a patient to die, by either providing some assistance to a patient in committing suicide, or in the form of active voluntary euthanasia, he or she may incur criminal liability for assisting suicide or murder, depending on the degree of their involvement in the patient's death.

So far, attention has focussed on the law regarding active and passive euthanasia performed at the request of the patient, in terms of theoretical liability. In the chapter which follows, attention will turn to an examination of the position in practice in terms of what doctors actually do and how the law is in fact applied.

CHAPTER IV

THE POSITION IN PRACTICE: DOCTORS' PRACTICES AND THE LAW APPLIED

Introduction

It is evident from the preceding chapters, that there is, in law, a significant distinction between passive and active euthanasia. The position is that passive euthanasia can in certain circumstances be lawfully performed.¹ It is, in fact, widely practised by the medical profession and accepted as legitimate medical practice.² In sharp contrast, the law treats active voluntary euthanasia as murder, regardless of the special circumstances,³ and it is officially condemned by the medical profession. Similarly, a doctor's active involvement in a patient's suicide is unlawful⁴ and the practice is rejected by medical organisations. The Hippocratic Oath is often cited as evidence of the medical profession's long tradition of opposition to active voluntary euthanasia and doctor-assisted suicide.⁵ Although doctors are no longer required to swear the Hippocratic Oath, it has in part been incorporated in the ethical codes of the various medical associations in Australia and the other common law jurisdictions

¹ See chapter II, 82.

² The Australian Medical Association (A.M.A.) has no official position on passive euthanasia but does support World Medical Association (W.M.A.) statements which, implicitly at least, accept the practice; see, for example, the W.M.A. *Declaration of Venice on Terminal Illness* (1983) and the W.M.A. *Declaration on Euthanasia* (1987). One common and well accepted form of passive euthanasia is the practice of making 'not for resuscitation' orders; T. Torda and P. Gerber, 'To Resuscitate or Not That is the Question' (1989) 151 *M.J.A.* 244; D. Stanley and D. Reid, 'Withholding Cardiopulmonary Resuscitation: One Hospital's Policy' (1989) 151 *M.J.A.* 257. For recognition of the permissibility of the withholding or withdrawing of treatment from terminally ill patients in some circumstances, see also the draft guidelines prepared by the Royal Prince Alfred Hospital Ethics of Medical Practice Sub-Committee, *The Ethics of Medical Practice and the Management of Terminally Ill Patients* (1992) 3-4. These guidelines were submitted to the Australian Health Ethics Committee (A.H.E.C.) for comment, and have since been widely circulated by the A.H.E.C.

For discussion of the position in other jurisdictions, see for the United Kingdom; British Medical Association (B.M.A.) Working Party Report, *Euthanasia* (1988) 46; in the United States; Statement of the Council of Judicial and Ethical Affairs of the American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment* March (1986); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) (hereafter referred to as the President's Commission Report); Hastings Center Report *Guidelines on the Termination of Life-Sustaining Treatment and Care for the Dying* (1987), (hereafter referred to as the Hastings Center Report); American Medical Association, House of Delegates, *Proceedings*, 140th Annual Meeting (1991); S. Wanzer *et al.*, 'The Physician's Responsibility to the Hopelessly Ill Patient' (1984) 310 *New Eng.J.Med.* 955; S. Wanzer *et al.*, 'The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look' (1989) 320 *New Eng.J.Med.* 844; and for Canada; the Canadian Medical Association (C.M.A.) *Statement on Terminal Illness* (1982) and *Joint Statement on Terminal Illness* (1984).

For the purposes of this thesis attention is focussed on the liability of doctors. It is, however, acknowledged that medical decisions to withhold treatment with the intention of hastening death will usually be made by a doctor, but in practice, are often carried out by the attending nurse; see M. Johnstone, *Bioethics* (1989) 249.

³ See chapter I, 11.

⁴ See chapter III, 87-88.

⁵ The relevant part of which provides: 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel.' For critical analysis of the status of the Hippocratic Oath, see chapter V, 219.

under consideration.⁶ Apart from the Hippocratic Oath and the codes of ethical practice which are based upon it, the question of active voluntary euthanasia has been specifically addressed by a number of medical associations. In 1987, the World Medical Association (W.M.A.) issued a *Declaration on Euthanasia* which states:

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.⁷

This declaration applies to all member associations of the W.M.A., including the Australian Medical Association (A.M.A.).⁸ The medical associations in the United Kingdom and the United States have formulated their own policies on the subject of active voluntary euthanasia, also condemning the practice.⁹

This chapter will be focussing on the position in practice with respect to active voluntary euthanasia and to a lesser extent, doctor-assisted suicide. Essentially, the object of this chapter is to highlight the discrepancies between the strict legal position and the position in practice in terms of what doctors actually do and how the law is applied, in order to demonstrate the inadequacies of the present law and the need for re-evaluation of the law's approach. A clear understanding of the position in practice and the extent to which it is at variance with strict legal principles is fundamental to any informed debate on this subject. The analysis in this chapter is, therefore, intended to lay a foundation for subsequent chapters containing ethical evaluation of active voluntary euthanasia¹⁰ and consideration of reform in this area.¹¹

On the basis of existing criminal law principles, any conduct which involves active steps to bring about the death of a patient amounts to murder, regardless of what may appear to be extenuating circumstances; for example, that the patient was in a terminal or incurable condition and had requested

⁶ The modern version of the Hippocratic Oath is now contained in the Declaration of Geneva adopted by the W.M.A. at its meeting in Geneva in 1948 and amended at its meeting in Sydney in 1968. At 3.1.9 it states that: 'I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity'.

⁷ Adopted by the 39th World Medical Assembly, Madrid, Spain, October 1987.

⁸ The official view of the A.M.A. has also been expressed through the submission of the A.M.A. (Vic. Branch) to the Parliament of Victoria, Social Development Committee Inquiry into Options for Dying With Dignity June (1986). For a summary of the submission, see Note, 'A.M.A. Opposes Euthanasia' (1986) *A.M.A. Vic. Branch News* 175.

⁹ British Medical Association, Report, *The Problem of Euthanasia* (1971), (Extracted in Trowell, *The Unfinished Debate on Euthanasia* (1973) Appendix A, 151-158); B.M.A. Working Party Report, *Euthanasia*, 67; House of Delegates of the American Medical Association, 1969-1978 *Digest of Official Action*, A.M.A. Dec. (1973); Statement of the Council of Judicial and Ethical Affairs of the American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment* March (1986). Note also the American Medical Association, House of Delegates, *Proceedings*, 140th Annual Meeting 1991 where euthanasia and physician-assisted suicide are rejected, but in more qualified terms; see chapter VI, 287-288.

Whilst the official position of the medical profession is to unequivocally condemn active euthanasia, there appears to be increasing dissension within medical associations with regard to this issue. (For discussion, see chapter VI, 261-290.

¹⁰ See chapter V.

¹¹ See chapters VI and VII.

that those steps be taken, and that the doctor had acted *bona fide* and out of compassionate motives. Similarly, liability will potentially arise for assisting suicide if a doctor provides a patient with the means to take his or her own life, and the law takes no account of the circumstances of the patient, or the doctor's motive in providing that assistance.

However, if one has regard to the position in practice with respect to active voluntary euthanasia and assisted suicide, it is evident that the law is out of touch with reality. Indications are that patients do request active euthanasia or suicide assistance and some doctors are responding to such requests. However, instances of prosecutions against doctors for euthanasing or assisting the suicide of their patients are exceedingly rare. Judging from the few cases which have arisen, and from the experience with cases of mercy killing or assisted suicide occurring outside of the medical context, such cases will generally be dealt with very leniently by the criminal justice system. It will also be shown that other aspects of medical practice, such as turning off life-support or the administration of drugs knowing that they will cause death, which would on strict legal principles attract criminal liability for murder, are characterised in such a way as to avoid the possibility of such liability. It will be argued that the prevailing discrepancies between legal theory and practice, and the deliberate distortion of legal principles, cause serious problems and if allowed to continue, threaten to undermine the law and bring it into disrepute.

This chapter will be divided into four parts: part I which sets out the current state of affairs with respect to the practice of active voluntary euthanasia; part II which examines the law in practice with respect to prosecutions of cases of active voluntary euthanasia and assisted suicide as well as cases of mercy killing; part III which outlines the discrepancies between theory and practice; and part IV which analyses the problems with the current legal characterisation of the withdrawal of life-support and the administration of pain-relieving drugs which hasten death.

PART I

The Current State of Affairs: Patients' Requests and Doctors' Practices

Active Euthanasia and Assisted Suicide: Patients' Requests

The object of this section is to examine the extent to which patients actually request active euthanasia or suicide assistance. Whilst there is obviously no reliable means of accurately measuring the full extent of patient demand, on the basis of available evidence there can be little doubt that *some* patients do specifically request their doctor to assist them to die.¹²

¹² For a discussion of the causes behind a patient's request for euthanasia, see P. Admiraal, 'Justifiable Euthanasia' (1988) 3 *Issues Law & Med.* 361.

An initial difficulty is that, to a large extent, we are reliant on the doctors dealing with such patients to provide information regarding the frequency of patients' requests for active euthanasia or assisted suicide. For a number of reasons, this is information which doctors may be reluctant to provide. A patient's request to die might be interpreted as a statement of the failure of the medical profession, particularly in light of the profession's traditional role of preservation of life.¹³ Furthermore, if some doctors respond to patient requests for active euthanasia or assisted suicide, it is unlikely to be a subject to which they want to draw attention in view of the present criminality of these practices.

Thus, doctors may have reasons for not disclosing the full extent of patient requests for active euthanasia and assisted suicide and it is in fact not uncommon for some doctors (or their professional associations) to claim that such requests are rarely made.¹⁴ Furthermore, even if it is accepted that a patient has made such a request, there may be some dispute regarding the proper interpretation of the patient's request; whether it constitutes a genuine request to die, or whether it is simply indicative of the patient's loneliness, fear, despair and pain, suggesting the need for support and/or more appropriate pain relief rather than the termination of life.¹⁵ Indeed, in some instances, the very expression of the patient's request for death has resulted in the patient's decision-making capacity being questioned.¹⁶ Whilst some medical opponents of active voluntary euthanasia have, on the basis of their own experience, disputed the existence of such requests, doctors who are known to have objections to these practices are unlikely to be asked for assistance by their patients.¹⁷

Although there clearly are difficulties in obtaining accurate and comprehensive information, the available evidence indicates that patients' requests for active euthanasia and assisted suicide are not uncommon. One of the most reliable sources of information available are the surveys which have been conducted of doctors' experiences in this area. The most significant Australian survey, dealing also with doctors' attitudes and practices with respect to active voluntary euthanasia, is that conducted by Professor Singer and Dr Kuhse of the Centre for Human Bioethics at Monash University.¹⁸ This survey was conducted by means of a questionnaire sent to 2000 doctors in Victoria, chosen at random from the Victorian Medical Register for 1986. Of the 2000 doctors questioned, 869 (46%) doctors returned completed questionnaires. When asked whether, in the course of their medical practice, they

¹³ For example, P. Turnbull, 'The Relationship of the Surgeon to the Patient with Advanced Malignant Disease' (1980) 92 *N.Z. Med. J.* 354, 355.

¹⁴ For example, R. Woodruff, 'Euthanasia for Cancer Patients: A Non-Debate' (letter) (1984) *M.J.A.* 548; B. Pollard, *Euthanasia* (1989) 63-66.

¹⁵ See, for example, R. Woodruff, 548; W. Weddington, 'Euthanasia: Clinical Issues Behind the Request' (1981) 246 *J.A.M.A.* 1949; J. Buchanan and W. Cosolo, 'A Patient's Right to a Good Death' (letter) (1991) 154 *M.J.A.* 710.

¹⁶ For example, the widely publicised case of John McEwan noted in chapter II, n. 66.

¹⁷ H. Kuhse and R. Young, 'A Rejoinder to Some Common Objections to Voluntary Euthanasia,' paper delivered to the ANZAAS Symposium; Modern Medical Technology and the Right to Die, No. 222, (1985) 1-2. Some evidence to support this view can be found in a recent survey of South Australian doctors; 50% of the respondent doctors who have treated incurably ill patients and who also believe that assisted dying is sometimes right have been asked by a patient for such help, but only 30% of respondent doctors who have treated incurably ill patients and who do not believe that assisted dying is sometimes right have been asked by a patient for such help; Medical Practitioners Concerned with Assisted Dying, Media Release, 'South Australian Doctors Help Incurable Patients to Die' 28 July 1992.

¹⁸ H. Kuhse and P. Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 *M.J.A.* 623.

had ever been requested by a patient to hasten his or her death, 40% of the respondents answered affirmatively.¹⁹ These results have been confirmed by a survey which has recently been conducted in South Australia to ascertain the attitudes and behaviour of South Australian doctor towards medical aid in dying.²⁰ Although on a smaller scale,²¹ this survey was conducted along similar lines to the Monash survey. According to the results obtained, 42% of the responding doctors who have treated terminally or incurably ill patients have been asked by a patient to actively assist him or her to die.²²

Since the doctors surveyed in the Monash and South Australian surveys were randomly selected these surveys can be taken as a representative response for doctors in Australia.²³ The results of these surveys are similar to those conducted in other jurisdictions.²⁴ They have also been confirmed through personal interviews conducted by the writer with doctors involved in the care of terminal and incurable patients.

In addition to information obtained from interviews and surveys of doctors, the occurrence of patient requests for active euthanasia and suicide assistance has been documented in a number of other ways. Occasionally, patient requests for active euthanasia or assisted suicide attract widespread media attention.²⁵ Not infrequently, the medical journals contain case-analyses regarding patient requests for active euthanasia or assisted suicide and how these should be dealt with from a practical and ethical point of view.²⁶

Notwithstanding the somewhat fragmentary nature of the available evidence, it is indisputable that some patients do specifically seek active euthanasia or suicide assistance. However, the true extent of patient demand has not yet been established. Because of the present illegality of active voluntary euthanasia and assisted suicide, patients may be reluctant to make such a request.²⁷

¹⁹ This figure does not disclose what proportion of those 40% of the respondents had been requested to take active steps to hasten the death of the patient as distinct from the withholding or withdrawing of treatment.

²⁰ This survey was conducted by a group of doctors in South Australia supportive of changes to the law - 'Medical Practitioners Concerned with Assisted Dying'

²¹ Questionnaires were sent to 1,000 doctors, randomly selected from the South Australian Medical Register.

²² Medical Practitioners Concerned with Assisted Dying, Media Release, 'South Australian Doctors Help Incurable Patients to Die' 28 July 1992.

²³ In addition to the available evidence with regard to doctors' experiences with patient requests for euthanasia, there is also evidence of the nursing profession quite frequently encountering requests for active euthanasia. In a survey conducted by Kuhse and Singer of 1,942 nurses in Victoria, 66% of respondents had been asked by a patient to hasten his or her death; H. Kuhse and P. Singer, 'Euthanasia: A Survey of Nurses' Attitudes and Practices' (1992) 21 *Aust. Nurses J.* 21, 22.

²⁴ For example, N. Brown *et al.*, 'The Preservation of Life' (1970) 211 *J.A.M.A.* 76, 77 where in a survey of 418 physicians, 12% had heard patient requests for positive (active) euthanasia; G. Williams, 'Euthanasia and the Physician' in M. Kohl, *Beneficent Euthanasia* (1975) 145, 146 referring to a National Opinion Poll conducted in England in 1964 and 1965 in which 48.6% of the doctors who responded were reported to have answered 'yes' to the question 'have you ever been asked by a dying patient to give him or her final release from suffering which was felt to be intolerable?'

²⁵ For example, the case of John McEwan noted in chapter II, n. 66. Note also Kylie Tennant's 'Last Letter to a Friend' *Sydney Morning Herald* 6 Feb. 1988.

²⁶ For example, B. Lo *et al.*, 'Ethical Decisions in the Care of a Patient Terminally Ill with Metastatic Cancer' (1980) 92 *Annals Internal Med.* 107; R. Higgs, 'Cutting the Thread and Pulling the Wool - a Request for Euthanasia in General Practice' (1983) 9 *J. Med. Ethics* 45.

²⁷ G. Williams, 'Euthanasia' (1973) 41 *Medico-Legal J.* 14-15.

Active Euthanasia and Assisted Suicide: Doctors' Practices

In the ongoing debate on the subject of euthanasia, it is frequently asserted or assumed that some doctors are involved in the practice of active voluntary euthanasia and assisted suicide.²⁸ In this part, an attempt will be made to make some assessment of doctors' involvement in these practices.

Because active voluntary euthanasia and assisted suicide²⁹ are presently unlawful, significant practical difficulties are encountered in ascertaining the exact extent of these practice. Doctors are naturally reluctant to openly admit any involvement in the practice of active voluntary euthanasia or assisted suicide for fear of criminal prosecution and/or disciplinary action taken against them by their professional organisations.³⁰ Furthermore, such activities are unlikely to come to the attention of others, since they will usually be performed in a clandestine fashion. Not only is the doctor likely to act secretly without onlookers, he or she may also readily conceal the true cause of death by indicating on the death certificate that the deceased died from natural causes.³¹ Apart from the fear of criminal prosecution and/or professional disciplinary action, there may be other reasons why doctors may be reluctant to divulge their involvement in these practices. For example, doctors may well be reluctant to breach patient confidentiality and indeed may have been specifically requested by the patient not to disclose to anyone the real cause of death. Doctors may also be reluctant to discuss such matters amongst their colleagues for fear of disapproval from their medical peers. There are, consequently, inherent limitations in obtaining reliable and comprehensive information regarding the practice of active voluntary euthanasia and assisted suicide by the medical profession, and the available information is, at times, fragmentary and anecdotal in nature.

Whilst these practical limitations must obviously be acknowledged, there is, nevertheless, almost incontrovertible evidence that a significant proportion of the medical profession has to some extent been involved in the practice of active voluntary euthanasia and assisted suicide.

Evidence regarding the practices of doctors with respect to active voluntary euthanasia and assisted suicide can be derived from a number of sources, including prosecutions of doctors, surveys of the medical profession and doctors openly admitting their involvement in these practices.

²⁸ For example, T. Marshall, *The Physician and Canadian Law* (1979) 26; C. Harris, 'Can Doctors Decide if Euthanasia is "The Good Death"?' (1983) 26 *Mod.Med.Aust.* 9; A. Downing, 'Euthanasia: The Human Context' in A. Downing and B. Smoker, *Voluntary Euthanasia* (1986) 24. There are, however, those who challenge these assumptions; e.g. H. Trowell, 136.

²⁹ For the purposes of this discussion assisted suicide will be used to refer to active forms of assistance, for example, where the doctor provides the patient with the necessary drugs to take his or her own life. See chapter III, 87.

³⁰ Some support for this view can be gleaned from survey results which indicate that the present illegality of the practice of active voluntary euthanasia has been a significant factor for those doctors who have not responded to patient requests. (See Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia,' 624.) It is possible to extrapolate from this that fear of legal or other damaging professional consequences is likely to be a significant factor in deterring doctors from being open in the practice of active voluntary euthanasia.

³¹ Since autopsies are a relatively rare procedure following the death of a terminal patient, the real cause of death (e.g. the administration of a lethal dose) is unlikely to be discovered.

Prosecutions of Doctors for Active Euthanasia and Assisted Suicide

In the United States and the United Kingdom there have been a number of cases involving the prosecution of doctors for their involvement in acts of euthanasia or assisting the suicide of their patients.³² Although such prosecutions are very rare and cannot be taken to reflect the true extent of the practice of active euthanasia or assisted suicide,³³ they certainly do bear out the contention that such practices do occur from time to time.

Survey Evidence of Doctors' Practices

Provided that they are professionally conducted, and assure the respondents' anonymity, surveys of doctors would appear to offer the most reliable information regarding the practice of active voluntary euthanasia and assisted suicide by the medical profession.

In the 1987 survey of doctors by the Monash Centre of Human Bioethics,³⁴ 2000 Victorian doctors were asked by means of a questionnaire whether they had ever taken active steps to bring about the death of a patient who had asked them to do so. Of the 869 doctors that returned completed questionnaires, 369 of the doctors answered this question. Of those, 107 (29%) indicated that they had taken active steps to bring about the death of a patient at the patient's request.³⁵ When questioned as to the frequency that active steps had been taken to bring about the death of a patient at the patient's own request, the responses were that 22 doctors had taken such steps once; 70 doctors two or three times and a further 22 more frequently.³⁶ This survey clearly reveals that a significant number of doctors in Victoria have practiced active euthanasia at the request of a patient.³⁷

³² See discussion below, 123-127.

³³ A number of reasons can be advanced for this dearth of prosecutions; as suggested earlier, doctors may, for a variety of reasons, be reluctant to be open in their practice of active voluntary euthanasia or assisted suicide and even in circumstances where active voluntary euthanasia or assisted suicide are known to be performed, there may be a reluctance on the part of prosecuting authorities to take action against a doctor. See discussion below, 128.

³⁴ Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 623.

³⁵ Note also the findings of an earlier Australian survey dealing with decision-making in critical illness; E. Bates, 'Decision Making in Critical Illness' (1979) 15 *A. & N.Z.J. of Sociology* 45, 47 where it is reported that a number of the doctors interviewed indicated that they had taken active steps to hasten the death of a patient.

³⁶ When questioned as to the reasons behind their actions, some doctors explained their conduct in terms of the relief of pain rather than bringing about death. However, quite a large number of doctors made it clear that they had acted with the intention of ending life. Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia,' 624. For further discussion with regard to the relationship between the administration of pain-relieving drugs which may hasten death and active euthanasia, see below, 163-175.

³⁷ In a related survey of the practices of Victorian nurses conducted by the same researchers, 25% of the 1,942 respondents said that they had, on at least one occasion, been asked by a doctor to engage in an action that would directly and actively end the life of a patient who had requested that his or her death be hastened. Of those, 85% had engaged in such action when asked to do so by a doctor and 80% had done so more than once. Kuhse and Singer, 'Euthanasia: A Survey of Nurses' Attitudes and Practices,' 22. A much smaller percentage of nurses (5%) indicated that they had complied with a patient's request to directly end his or her life without having been asked by a doctor to do so. These results are of relevance, reflecting not only the practices of the respondent nurses, but also of the doctors who are reported to have requested that the nurses take active steps to end the life of a patient at the patient's request.

The recent survey of South Australian doctors has produced remarkably similar results. In that survey, doctors were questioned whether they had ever been asked by an incurably or terminally ill patient to actively assist him or her to die. Twenty-nine per cent of responding doctors who had ever been asked by an incurably or terminally ill patient to actively assist him or her to die acknowledged having done this for at least one patient.

On the basis of the Monash and South Australian surveys, there is evidence to suggest that more than one quarter of the respondent doctors involved in the care of terminally or incurably ill patients have responded to a patient's request to take active steps to bring about the patient's death and some have done so on more than one occasion. These results are clearly significant and there appears to be no reason to suggest that these responses from Victorian and South Australian doctors, randomly selected, would not be broadly representative of Australian doctors generally.

The results from the Australian surveys are consistent with surveys of doctors' practices conducted in the United States. In 1987 the Hemlock Society (a national group advocating active voluntary euthanasia³⁸) conducted a survey among Californian doctors using the same questionnaire as used in the Monash survey. The questionnaire was sent to 5000 doctors of whom some 588 responded. Seventy-nine of the doctors surveyed (nearly 23%) indicated that they had deliberately taken the lives of terminal patients who had asked to die, and some had done so on more than one occasion.³⁹ Other less extensive surveys conducted in the United States have also revealed that active euthanasia is being performed by doctors.⁴⁰

There have been relatively few surveys which have attempted to examine the extent of doctors' involvement in assisted suicide. One survey which did address this issue was a 1988 study of all licensed Colorado doctors conducted by the Center for Health Ethics and Policy at the University of Colorado at Denver. According to the results of this survey, a small, but nevertheless significant, proportion of doctors admitted to helping patients 'stockpile' lethal doses of medication, knowing that the drugs might be used to commit suicide.⁴¹

³⁸ See chapter VI, 250-253.

³⁹ Note, 'Most California Doctors Favour New Euthanasia Law' (1988) 31 *Hemlock Q.* 1-2.

⁴⁰ A. Levisohn, 'Voluntary Mercy Deaths' (1961) 8 *J. Forensic Med.* 57 referring to a survey of 250 Chicago internists and surgeons, of which 156 replied. In answer to the question: 'In your opinion do physicians actually practice euthanasia in instances of incurable adult sufferers?' 61% agreed that physicians do practice euthanasia, both in the active and passive form. See also H. Bosmann, J. Kay and E. Conter, 'Geriatric Euthanasia: Attitudes and Experiences of Health Care Professionals' (1987) 22 *Social Psychiatry* 1 for reference to a survey conducted in Cincinnati, Ohio of 190 health care professionals principally involved with long term care facilities. With respect to active euthanasia, 44% had heard of such cases and 20% had taken such action.

⁴¹ Center for Health Ethics and Policy Graduate School of Public Affairs, University of Colorado at Denver, *Withholding and Withdrawing Life-Sustaining Treatment* (1988) 17. (Hereafter referred to as the Center for Health Ethics and Policy Report.) Over 4% (4.3% of all doctors and 4.7% of primary care doctors) acknowledged providing such aid to their patients. Note also Bates, 47 where, on the basis of a series of interviews with doctors in Sydney, it was reported that one doctor had indicated that he provided patients with the means for committing suicide.

Admissions by Individual Doctors

Notwithstanding the present illegality of active voluntary euthanasia and assisted suicide, doctors have, on occasion, openly admitted that they have participated in these practices. Indeed, in recent years there appears to be an increasing number of doctors who have admitted that they have actively ended the life of a patient or assisted with the patient's suicide. A recent public admission was made by an Australian doctor, Dr Rodney Symes (a Melbourne urologist) who acknowledged having helped three people to commit suicide in the past 15 years.⁴² Similar admissions have been made in the other jurisdictions under consideration. For example, in the United States, Dr. Timothy Quill described in an article submitted to the *New England Journal of Medicine* how he had prescribed sleeping pills to a patient suffering from leukemia in order that she could kill herself.⁴³ Another doctor who has openly admitted his involvement in the practice of physician-assisted suicide is Dr Jack Kevorkian, a retired Michigan pathologist. Dr Kevorkian has developed a 'suicide machine' which can be activated by a patient wanting to take his or her life.⁴⁴ Since 1990, when he first used his suicide machine, he is reported to have assisted a total of six patients to commit suicide.⁴⁵ There have also been instances of admissions by doctors in the United Kingdom. Such accounts include that of Dr George Mair who in 1974 published a book entitled *Confessions of a Surgeon* in which he openly admitted that he had performed active euthanasia during his time in medical practice.⁴⁶

Other admissions to the practice of active voluntary euthanasia have been less public, or have been made anonymously. For example, there have been reports of medical meetings at which doctors have admitted to having administered active euthanasia.⁴⁷ Anonymous admissions have generally taken the form of publications⁴⁸ and include a much publicised incident in the United States, in which a resident doctor admitted that he had injected a fatal dose of morphine into a 20 year old patient dying of ovarian cancer.⁴⁹

⁴² The *Australian* 9 March 1992. See also the admission by Dr John Woolnough who openly admitted in taking part in a case of active voluntary euthanasia (the *Australian* 22 June 1973) and the reported admission of a retired psychologist suffering from Aids who has said he has helped 8 people with the disease to kill themselves by providing them with a fatal dose of prescription drugs; see Note, 'Psychologist Helped Eight People to Die' (1990) 40 *V.E.S. Newsletter* 5.

⁴³ T. Quill, 'Death and Dignity: A Case of Individualised Decision Making' (1991) 324 *New Eng.J.Med.* 691. For discussion, see N. Newman, 'Euthanasia: Orchestrating "The Last Syllable of....Time"' (1991) 53 *U.Pitt.L.Rev.* 153, 158-160.

⁴⁴ The first few incidents involved a device which enabled a patient to release a fatal dose of potassium chlorate after the patient had been connected to the machine. The more recent incidents have involved a device whereby the patient can activate the release of carbon monoxide through a mask.

⁴⁵ For further discussion, see chapter VI, 286-287.

⁴⁶ G. Mair, *Confessions of a Surgeon* (1974) 86. Note also the examples referred to in the Linacre Centre, Working Party Report, *Euthanasia and Clinical Practice* (1982) 11; and the admission by a London doctor referred to in Note, 'The Dying Patient: Current Practice' (1989) 36 *V.E.S. Newsletter* 1. See also the reference to admissions by doctors in D. Humphry and A. Wickett, *The Right to Die* (1986) 325-326; R. Russell, *Freedom to Die* (Revised ed., 1977) 80, 137, 389-390; J. Fletcher, *Moral and Medicine* (1954) 205-206.

⁴⁷ For example, Linacre Centre, *Euthanasia and Clinical Practice*, 11; Fletcher 205-206.

⁴⁸ For example, Note, 'Euthanasia' (1984) 2 *Int'l.Rev.Contemp. Law* 63.

⁴⁹ Note, 'It's Over, Debbie' (1988) 259 *J.A.M.A.* 272. This admission provoked a storm of protest, particularly because of the manner in which the killing had occurred; the resident had been woken up in the middle of the night, had had no previous contact with the patient, and had only hastily informed himself of her condition without consulting her doctor before administering the lethal dose. Criticism has also been levelled at the editor of the journal, G. Lundberg M.D., for his decision to publish the article, at least without any indication of disapproval of the practice. Legal action was in fact commenced against the editor in order to obtain further details of the incident but the Cook County

Evidence from Interview Work

In the course of confidential interview work conducted by the writer, quite a number of doctors have been prepared to admit that they have, on occasion, deliberately hastened the death of a patient at the patient's request. In some instances this was done under the guise of pain relief with the drugs manifestly being prescribed for the relief of the patient's pain, but the doctor intending thereby to hasten the patient's death. A significant number of doctors have also admitted that they have assisted patients in committing suicide by providing the necessary drugs and information.

Other Forms of Active Assistance in the Termination of Life

Apart from the deliberate administration of a lethal dose, there are other forms of medical practice which may, in effect, involve active assistance in the termination of life, namely the withdrawal of life-support (for example, turning off a ventilator),⁵⁰ and the administration of pain-relieving drugs which hasten death.

Withdrawal of Life-Support

Life-support assistance can take a variety of forms; for instance, a ventilator which supports the respiratory function of the patient, or artificial feeding, (e.g. intravenous or naso-gastric) which provides a patient with nutrition and hydration. The withdrawal of such life-support measures may arise in a variety of circumstances. It may, for example, be done at the request of a patient who has decision-making capacity and is dependent on life-support.⁵¹ Alternatively, artificial ventilation may be terminated in respect of a brain-damaged or comatosed patient in order to determine whether the patient is able to breathe spontaneously,⁵² or because the treating doctors have decided that continuation of life-support is medically futile. It is a fairly common occurrence in medical practice for doctors to withdraw life-support from a patient and this is widely accepted, even in the most conservative medical circles,⁵³ to be proper medical practice in appropriate circumstances.⁵⁴

Court upheld the right of the journal to withhold the name of the author; *N.Y. Times* 19 March 1988. (For further discussion, see D. Gardy, 'The Doctor Decided on Death' (1988) 15 Feb. *Time* 31; W. Gaylin *et al.*, 'Doctors Must Not Kill' (1988) 259 *J.A.M.A.* 2139; Note, 'It's Over Debbie' and the Euthanasia Debate' (1988) 259 *J.A.M.A.* 2142; M. Bloom, 'Article Embroils *J.A.M.A.* in Ethical Controversy' (1988) 239 *Science* 1235; Newman, 155-158.

⁵⁰ The writing of 'not for resuscitation' orders could also be included in this category since it involves a bodily movement even though it is part of a broader plan of non-intervention.

⁵¹ For example, the publicised case which occurred in St. Vincent's Hospital, Melbourne, where the hospital acted upon the request of a woman suffering from motor-neuron disease to remove the ventilator which was supporting her breathing. The woman died shortly after the ventilator was removed. See the *Herald* 22 March 1988, the *Age* 23 March 1988 and discussion by N. Tonti-Filippini, 'Some Refusal of Treatments which Changed the Law of Victoria' (1992) 157 *M.J.A.* 277, 278.

⁵² P. Skegg, *Law Ethics and Medicine* (Revised ed., 1988) 164; I. Kennedy, 'Switching Off Life Support Machines: The Legal Implications' (1977) *Crim.L.Rev.* 443, 445-448.

⁵³ This is highlighted by the case at St. Vincent's Hospital (a Catholic institution); see above, n. 51.

⁵⁴ For evidence of the occurrence and acceptability of this practice, see the President's Commission Report, (summary of the commission's conclusions) 2-9; Hastings Center Report, 35-42, 59-62; L. Schneiderman and R. Spragg, 'Ethical Decisions in Discontinuing Mechanical Ventilation' (1988) 318 *New Eng.J Med.* 984; J. Behnke and S. Bok, *Dilemmas of Euthanasia* (1975) 114-115.

Administration of Pain-Relieving Drugs which Hasten Death

Another aspect of medical practice which involves active assistance in the termination of life is the administration of pain-relieving drugs which hasten death. Many patients, particularly those suffering from a terminal condition such as cancer, may experience considerable pain and other distressing symptoms.⁵⁵ There are a range of analgesic or pain-killing drugs available which may be administered to relieve pain, but which may have the effect of shortening the patient's life. A typical example is the drug morphine. Regular increases in dosage may be necessary because the effects of the disease become more severe or because the patient has developed tolerance to the drug.⁵⁶ However, excessive doses of morphine may lead to the death of the patient through respiratory depression or bronchial pneumonia.⁵⁷ Thus, doctors may face the dilemma of leaving the patient's pain unrelieved, or administering the minimum dose to relieve pain, even though this may hasten the death of the patient.⁵⁸ Whilst indications are that as a result of increased availability of pain control drugs and knowledge of their use, this problem is not as great as it once was, difficulties nevertheless remain.⁵⁹

It is widely accepted amongst the medical profession that where a patient is beyond recovery, it is legitimate medical practice to administer pain-relieving drugs even though they may incidentally hasten the death of a patient,⁶⁰ and there is considerable evidence that this practice is widespread.⁶¹

⁵⁵ R. Twycross, 'Incidence and Assessment of Pain in Terminal Cancer' in R. Twycross and V. Ventafridda (eds.) *The Continuing Care of Terminal Cancer Patients* (1980) 65-74.

⁵⁶ B.M.A. Working Party Report, *Euthanasia*, 12.

⁵⁷ It is also possible that the use of morphine may have the effect of extending the life of the patient, because the patient is more rested and painfree. See, for example, R. Twycross, 'Debate: Euthanasia - A Physician's Viewpoint' (1982) 8 *J. Med. Ethics* 86, 88; President's Commission Report, 73-77; Hastings Center Report, 73. Indeed, some doctors contend that if morphine is used correctly it should never have the effect of shortening life; see, for example, R. Barry and J. Maher, 'Indirectly Intended Life-Shortening Analgesia: Clarifying the Principles' (1990) 6 *Issues Law & Med.* 117, 123-136.

⁵⁸ See also G. Williams, *The Sanctity of Life and the Criminal Law* (1956) 287.

⁵⁹ Law Reform Commission of Western Australian, Project No. 84, Report, *Medical Treatment for the Dying* (1991) 25 (hereafter referred to as the Law Reform Commission of Western Australian Report).

⁶⁰ According to the Hippocratic Oath, one of the aims of medicine is the prevention of suffering and this is also reflected in the official position of the medical profession. See, for example, the W.M.A. Statement of Policy on the *Care of Patients with Severe Chronic Pain in Terminal Illness* (1990); B.M.A. Working Party Report, *Euthanasia*, 40; Statement of the Council of Judicial and Ethical Affairs of the American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment* March (1986); American Medical Association, House of Delegates, *Proceedings*, 140th Annual Meeting (1991); A. Burton, *Medical Ethics and Law* (2nd ed., 1974); Royal Prince Alfred Hospital, Ethics of Medical Practice Sub-Committee, Draft Guidelines, *The Ethics of Medical Practice and the Management of Terminally Ill Patients* (1992) 3; Hastings Center Report, 73, 128; S. Wanzer *et al.*, 'The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look,' 846-847. Note also I. Kennedy and A. Grubb, *Medical Law* (1989) 1076 where the authors refer to a national survey conducted in the United States addressing *inter alia*, the issue of pain relief; 82% of physicians questioned thought that it was ethically permissible to administer drugs to relieve a patient's pain even at the risk of shortening life. Interviews conducted by the writer with doctors involved in the care of the terminally ill also confirms that most doctors are willing to administer pain-relieving drugs knowing that the patient's death may be hastened as a result. There also appears to be widespread agreement as to the moral acceptability of this practice. See, for example, the findings of the Parliament of Victoria Social Development Committee in its Second and Final Report, *Inquiry into Options for Dying with Dignity* (1987) 89, 93-95.

⁶¹ See, for example Bates, 47, the Center for Health Ethics and Policy Report, 16-17; Behnke and Bok, 111 (referring to a survey conducted by D. Crane); and J. Gould and Lord Craigmyle, (eds.) *Your Death Warrant?* (1971) 118.

PART II

The Law in Practice

All instances of doctors being charged and prosecuted for having performed active euthanasia upon a patient or assisted the suicide of a patient are of obvious relevance in analysing the approach of the law in practice to these activities. It seems, however, that very few such prosecutions arise and it will be argued that this is in itself significant.

By contrast, there have been quite a number of prosecutions outside the medical context involving mercy killings by non-medical persons, be it a spouse, relative or friend of the deceased. There are clearly important differences between cases of medically administered active voluntary euthanasia and family mercy killing, particularly in relation to the personal emotional element which is frequently present in family mercy killing cases but is unlikely to be a factor in the context of medically administered euthanasia.⁶² Notwithstanding these differences, an examination of these non-medical mercy killings and their treatment in the criminal justice system may shed some light on how cases involving prosecutions of doctors are likely to be dealt with in practice if they were to come before the courts more frequently.

Prosecutions of Doctors for Active Euthanasia or Assisted Suicide⁶³

Interestingly enough, there appears to have been no recorded case in Australia involving the prosecution of a doctor for having performed active voluntary euthanasia.⁶⁴ However, this dearth of prosecutions cannot be taken as evidence that such cases have not in fact occurred. It is far more likely

⁶² Note, however, there have been a number of cases in the United States where doctors have been prosecuted as a result of their involvement in the death of a family member. See below, 125.

⁶³ It should be noted that there have also been cases involving the prosecution of nurses for murder or assisting suicide of their patients and these cases have frequently been dealt with leniently in the criminal justice system; e.g. *R v Barnes* (unreported) 16 Nov. 1981, S.C. N.S.W. in which the defendant, a male nurses' assistant, was charged with attempted murder after allegedly administering an unauthorised dose of pethidine to an elderly patient. In the police record of interview, the defendant had admitted administering a large dose of pethidine to the patient in order to kill her but claimed that the patient had been in severe pain and that he acted out of merciful motives. The defendant pleaded not guilty to the charge of attempted murder and he was acquitted. For reference to an American case, in which a nurse was acquitted after administering a fatal dose of morphine to a patient, see D. Humphry, (ed.) *Compassionate Crimes, Broken Taboos* (1986) 16.

⁶⁴ The only Australian case in which a doctor has been charged with the murder of a patient is the case *R v Lim* (unreported) 25 Jan. 1989, P.S. W.A. Whilst there was some suggestion that this may have been a case of active euthanasia, it cannot readily be characterised as such. This case, which came before the Perth Court of Petty Sessions by way of committal proceedings, concerned the death of an elderly female patient from an alleged morphine overdose which was administered by Dr Lim after the patient had suffered a heart attack. In the committal proceedings which followed, the prosecution alleged that Dr Lim had murdered the patient in order to benefit under her will. There was evidence before the court that he had received various gifts of money and property from the patient before she died and that he had been made executor and residual beneficiary under her will. There was, however, conflicting evidence about the cause of death and whether the morphine administered was a potentially fatal dose. At the end of committal proceedings the magistrate ruled that there was no evidence upon which a jury could convict and the case against Lim was dismissed.

to be evidence of the invisible nature of such acts⁶⁵ and/or the unwillingness of prosecuting authorities to institute proceedings against members of the medical profession.

In both the United States and the United Kingdom, there have been a number of prosecutions of doctors for either murder or attempted murder, brought on the grounds of the doctors' involvement in active euthanasia. The first of such cases to arise in the United States was the much publicised prosecution of Dr Hermann Sander in New Hampshire in 1950 for the murder of a patient.⁶⁶ Dr Sander had evidently injected air into a vein of his cancer-ridden patient, with the intention of bringing about her death. This was clearly established from the patient's hospital records, in which Dr Sander had made the following entry: 'Patient was given 10 c.c. of air intravenously repeated four times. Expired within ten minutes after this was started'. At his trial, Dr Sander did not seek to deny that this had occurred. Nor did he attempt to allege that his action was in any way justified.⁶⁷ His defence was simply argued on the basis that there was no evidence that he had in fact caused the patient's death.⁶⁸ The jury acquitted the doctor of the murder charges, apparently accepting his defence that his acts were not the necessary proximate cause of the patient's death.

Another American case involving the prosecution of a doctor for having administered active euthanasia to a patient is *People v Montemarano*.⁶⁹ In that case, Dr Vincent Montemarano was charged with the murder of his 59 year old patient who was suffering from terminal cancer of the throat. There was evidence before the court that the doctor had administered to the patient a fatal dose of potassium chloride and that the patient had died shortly after. As in the earlier *Sander* case, the issue of euthanasia was not specifically raised by the defence.⁷⁰ It was argued on behalf of the doctor that the patient had died before the potassium chloride was administered or alternatively, that the patient had died from other causes. The case was tried before a jury and the doctor was acquitted of all charges.⁷¹

It should be noted that in neither case was the jury directly confronted with deciding a case of acknowledged medical euthanasia, carried out deliberately by the doctor with the object of terminating the patient's suffering. In both cases, the doctors' defence proceeded on the basis that the doctor had not

⁶⁵ D. Crane, 'Dying and Its Dilemma as a Field of Research' in O. Brim *et al.*, (eds.) *The Dying Patient* (1970) 303, 306.

⁶⁶ *People v Sander* (unreported) *N.Y. Times* 10 March, 1950. For analysis of this case, see T. Sachs, 'Criminal Law: Humanitarian Motive as a Defense to Homicide' (1950) 48 *Mich.L.Rev.* 1199.

⁶⁷ D. Meyers, *Medico Legal Implications of Death and Dying* (1981) 121. There appears to be some disagreement amongst commentators as to whether the patient had requested such assistance. Compare for example, Behnke and Bok, 53; and Y. Kamisar, 'Some Non-Religious Views Against Proposed Mercy-Killing Legislation' (1958) 42 *Minn.L.Rev.* 969, 1019.

⁶⁸ Evidence was given at the trial that the patient might already have been dead when Dr Sander gave her the injection and that in any event, 40 c.c. of air would be insufficient to cause death; see W. Baugham, J. Bruha and F. Gould, 'Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations' (1973) 48 *Notre Dame Law.* 1202, 1214.

⁶⁹ (Unreported) (1974) Nassau County Court, (N. Y.).

⁷⁰ L. Goldsmith, 'Physician Acquitted of Charges of Murdering Patient' (1974) 2 *J.L.Med.* 47, 48.

⁷¹ *N.Y. Times* 13 Jan. 1974.

caused the patient's death and the jury in each case apparently accepted these arguments despite considerable evidence to the contrary.⁷²

There have also been a number of other cases which have come before the courts in the United States involving prosecution against doctors for murder in circumstances suggesting active euthanasia where the doctor was a relative of the deceased.⁷³ In a 1986 case, Dr Joseph Hassman was charged with the murder of his mother-in-law who had been suffering from Alzheimer's disease. He pleaded guilty to killing her by injecting the pain-killer Demerol into her feeding tube. He was sentenced to two years probation, fined \$10,000 and ordered to perform 400 hours of community service by a New Jersey Superior Court judge.⁷⁴ In imposing the sentence, the judge commented that no purpose would be served by committing the defendant to gaol and suggested that having regard to all the circumstances, gaoling the offender would constitute 'a serious injustice'.⁷⁵ In 1988 Dr Peter Rosier was charged with the murder of his wife who had been suffering from terminal cancer. Dr Rosier had admitted to the media, some months after the death of his wife, that he had given his wife drugs at her request so that she could end her life. He pleaded not guilty to the charge of murder and notwithstanding factual evidence which clearly indicated Dr Rosier's criminal liability for taking steps to assist his wife to die, he was acquitted by the jury.⁷⁶

Another noteworthy case is that of Dr Timothy Quill, (referred to earlier)⁷⁷ who had publicly admitted assisting a cancer patient to commit suicide. He had been attending the patient for quite a number of years and when the patient requested assistance to die, he provided her with a prescription for barbiturates and information on how to use them in order to commit suicide. As a result of this action, Dr Quill was brought before a grand jury. However, the grand jury refused to indict him on charges of assisting suicide.⁷⁸

⁷² Behnke and Bok, 53-4; R. Veatch, *Death Dying and the Biological Revolution* (1976) 80. Another case involving a prosecution of a doctor for murder arose in 1985 when Dr John Kraai was charged with the murder of his patient who had been suffering from Alzheimer's disease. Dr Kraai committed suicide before the matter came on for trial; see Humphry and Wickett, 145-147.

⁷³ Note also the Canadian case involving the prosecution of Dr Ernest Pedley in 1973 for the attempted murder of his cancer-stricken wife. Dr Pedley entered a plea of guilty to attempted murder and was convicted to imprisonment for six months; see G. Parker, 'You Are a Child of the Universe: You Have a Right to be Here' (1977) 7 *Manitoba L.Rev.* 151, 165.

⁷⁴ *People v Hassman* (unreported) *N. Y. Times* 20 Dec. 1986.

⁷⁵ *Ibid.*

⁷⁶ *People v Rosier* (unreported) *Washington Post* 2 Dec. 1988; Note, 'Dr Rosier's Acquittal Both a Victory and a Warning' (1989) 34 *Hemlock Q.* 1.

⁷⁷ See above, 120.

⁷⁸ *N.Y. Times* 27 July 1991. Note should also be made of the charges against Dr Kevorkian for having assisted in the suicide of a number of patients. However, because these suicides took place in the State of Michigan where assisting suicide is not a specific offence, charges were instead brought for murder but were dismissed because the prosecution could not show that Dr Kevorkian had activated the suicide device so as to constitute homicide. For further discussion, see above, 120 and chapter VI, 286-287. Although there have been other instances of doctors admitting their participation in the suicide of patients they have generally not resulted in prosecution. This can, in part, be explained by the tendency of the doctors not to disclose the identity of the deceased patient, thereby making it difficult for the prosecution to prove liability. There does, however, appear to be a distinct disinclination on the part of police and prosecuting authorities to investigate or take action in respect of such cases. See further discussion below, 128.

In recent years, there have also been a number of prosecutions of doctors in the United Kingdom for the attempted murder of their patients.⁷⁹ In 1986 criminal proceedings were brought against Dr Carr for having injected a massive dose of phenobarbitone into a patient who had terminal cancer. The patient had died two days later and since natural causes could not be ruled out as the cause of death, the charge was one of attempted murder.⁸⁰ The prosecution claimed that the dosage could not possibly be justified on any genuine medical basis and that it had been deliberately administered in order to hasten the death of the patient.⁸¹ As part of the prosecution case it was alleged that the doctor had said that 'he wished the patient should be allowed to die with dignity.'⁸² Dr Carr, who had pleaded not guilty to the charge of attempted murder, alleged that the dose had been given in error.⁸³ This contradicted an earlier statement he had made to the police in which he claimed that he had only administered a fraction of the dose.⁸⁴ Notwithstanding the weight of evidence against him and a summing up by the judge hostile to the defence, the jury acquitted the doctor of the charge.⁸⁵ This result was hailed by the press as the product of the jury's determination not to brand a doctor a criminal who they believed had acted honourably and mercifully.⁸⁶

A recent case which has attracted much publicity in the United Kingdom is the prosecution and conviction of Dr Cox for the attempted murder of one of his patients.⁸⁷ Cox, a rheumatologist, was charged with attempted murder following the death of a 70 year old terminally ill patient who had asked him to put her out of her misery.⁸⁸ The deceased, who had been a patient of Dr Cox for 13 years, had rheumatoid arthritis, complicated by gastric ulcers, gangrene and body sores.⁸⁹ She was crippled from her condition and in great pain. There was evidence before the court that five days before her death the patient had rejected further medical treatment other than pain-killers in a final decision to give up her fight for life.⁹⁰ She had apparently begged Cox to 'finish her off' but he had refused, promising instead to relieve her pain to allow her to live her final days in dignity.⁹¹ When other pain-killing measures failed to bring relief, Cox administered a large dose of potassium chloride, twice the amount which would normally prove fatal and the patient died within minutes.

79 The prosecutions against doctors in the United Kingdom include *R v Arthur* (unreported) *The Times* 6 Nov. 1981 concerning the prosecution of Dr Leonard Arthur for attempted murder with regard to the death a Down's syndrome baby but it is submitted that this case falls outside the ambit of the present analysis, since it did not clearly involve active euthanasia.

80 *R v Carr* (unreported) *Yorkshire Post* 12 Nov. 1986.

81 *Ibid.*

82 *Ibid.*

83 *Yorkshire Evening Post* 19 Nov. 1986.

84 *Yorkshire Evening Post* 18 Nov. 1986. Dr Carr had initially claimed that he had only injected 150 m.g.'s of phenobarbitone but later accepted that he had given the patient 1,000 m.g.'s.

85 *The Sunday Times* 30 Nov. 1986.

86 *Ibid.*

87 *The Times* 22 Sept. 1992.

88 He was evidently charged with attempted murder rather than murder because the deceased had been cremated before the police investigation could establish that the drugs were the cause of death; Note, 'Attempted Murder Conviction of Euthanasia Doctor in England' (1992) 62 *V.E.S.N.S.W. Newsletter* 2.

89 *The Times* 22 Sept. 1992.

90 *The Australian* 21 Sept. 1992.

91 *Ibid.*

Cox admitted that he had administered the drug but maintained that his primary intention was not to kill his patient but merely to relieve her suffering. After eight hours of deliberation, the jury, several overcome with emotion and weeping, reached a majority verdict of 11-1 against Cox on what the judge had described as 'the most clear and compelling evidence'.⁹² Cox was given a 12 month prison sentence, but in recognition of the fact that the public interest would not be served by immediately jailing the consultant, the sentence was suspended. Justice Ognall of the Winchester Crown Court described the situation as one in which the consultant had allowed his distress over the suffering endured by his patient to overcome his professional duty. His Honour said 'such conduct can never be legally excused. However, sometimes it can be explained.'⁹³ In sentencing Cox, Justice Ognall told him that his conduct in administering a lethal injection to his patient had not only been criminal, but also a betrayal of his unequivocal duty as a physician.⁹⁴ Counsel for the defendant had urged the judge to give his client an absolute discharge in view of the exceptional circumstances of the case but the judge said that deliberate conduct by a doctor aimed at bringing about the death of a patient required, as a matter of principle, to be marked by a term of imprisonment.⁹⁵

The conviction against Cox is of consequence, being one of the rare instances where a doctor has been found criminally liable for having taken active steps to hasten the death of a suffering patient. Moreover, it is significant that a sentence of imprisonment was imposed, albeit one which was ultimately suspended. The comments made by Justice Ognall and the course that he took against Cox indicates that some members of the judiciary would be inclined to bring the criminal law to bear against doctors for any action taken to deliberately hasten the death of a patient. Although the sentence imposed may, in some respects, appear lenient, the judge had the discretion to impose a lighter penalty, including the possibility of a conditional discharge, which arguably would have been more appropriate in all the circumstances.⁹⁶

There have also been a number of prosecutions for murder in the United Kingdom in circumstances where the doctor alleged that the death inducing drugs administered to the patient were for the relief of pain and, therefore, his action did not constitute murder.⁹⁷ However, in both of these cases the doctor was acquitted of the charge.⁹⁸

⁹² *The Times* 22 Sept. 1992.

⁹³ *Ibid.*

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

⁹⁶ See also D. Brahm, 'Euthanasia: Doctor Convicted of Attempted Murder' (1992) 340 *Lancet* 783 where she suggests that in comparison with the sentences imposed against doctors in a number of recent convictions for criminal recklessness, (6 months, suspended) the sentence against Cox was unduly harsh.

⁹⁷ *R v Adams* (unreported). See H. Palmer, 'Dr Adams' Trial for Murder' (1957) *Crim.L.Rev.* 365; *R v Ludwig* (unreported) *The Times* 16 March 1990. These cases are dealt with in detail below, 165-170 in the context of the discussion with respect to pain-relieving drugs which hasten death.

⁹⁸ In *R v Adams* the defendant was found not guilty after a very favourable direction from the Judge, and in *R v Ludwig* the prosecution did not offer any evidence against the defendant at his trial. See further discussion below, 165-170.

Perhaps the most significant point to emerge from the foregoing analysis is the sparsity of cases involving the prosecution of doctors for either administering active euthanasia or assisting the suicide of their patients.⁹⁹ This contrasts markedly with the available information regarding doctors' practices which strongly suggests that a not insignificant proportion of doctors have performed active voluntary euthanasia or assisted the suicide of a patient. A number of informed suggestions can be put forward by way of possible explanation for this dearth of cases involving prosecutions of doctors. First of all, as noted earlier,¹⁰⁰ in view of the present criminality of active euthanasia and assisted suicide, doctors' involvement in these practices is understandably covert and, therefore, unlikely to come to the attention of others. Furthermore, although such cases are widely known to occur, there appears to be a distinct reluctance by the police and prosecuting authorities to become involved in this area.¹⁰¹ However, once a matter comes to the attention of the police and prosecuting authorities through the reporting of others or even by the doctor's own admission, the authorities have no real choice but to proceed with a prosecution, provided there is sufficient evidence upon which a reasonable jury, properly instructed, could convict.¹⁰² From an evidentiary point of view, one of the main practical difficulties in securing a murder conviction against a doctor for having killed a patient by administering a lethal dose or by other means is proving that the death of the deceased was caused by the act of the doctor.¹⁰³ Particular difficulties are likely to arise in circumstances where the patient was in a terminal condition and had already been receiving large doses of drugs over an extended period of time. In these circumstances it may be very difficult for the prosecution to establish that the doctor had caused the patient's death.¹⁰⁴ Lack of evidence may, therefore, be a ground for not instituting, or not proceeding with a prosecution against a doctor. Where a prosecution does proceed, judging from the few cases which have come before the courts, the prospect of securing a murder conviction against a doctor for administering active voluntary euthanasia in a *bona fide* medical context seems fairly remote. Almost invariably, doctors have escaped criminal liability even though, in many instances, the evidence has clearly indicated criminal activity. As the few reported cases have shown, juries are often reluctant to convict doctors who have acted *bona fide* and out of compassionate motives, and are therefore likely to seize upon any defect in the evidence as a reason for acquitting the defendant. Indeed,

⁹⁹ Of interest in this regard is a Canadian case in which a Quebec doctor helped a patient suffering from AIDS to die. The doctor has been reprimanded by the Disciplinary Committee of the Quebec Corporation of Physicians, but was not recommended for prosecution; Note, 'Quebec Doctor Not Prosecuted for Euthanasia' (1992) Vol. 6 No. 3 *Dying with Dignity Newsletter* 2.

¹⁰⁰ See above, 115, 117.

¹⁰¹ This conclusion has been reached following numerous interviews with heads of police and prosecuting authorities throughout Australia. See also Williams, *The Sanctity of Life and the Criminal Law*, 291-2; Levisohn, 66. Note, however, the statement by the New South Wales Attorney-General made in the wake of the release of the results of the survey of Victorian doctors' attitudes and practices regarding euthanasia (see above, 115-116) to the effect that doctors who carry out mercy killings would definitely be prosecuted; *Daily Telegraph* 23 June 1988. Note also in the United Kingdom, following the *R v Arthur* case, (unreported) *The Times* 6 Nov. 1981 (see above, n. 79) it was announced by the Crown prosecutor that doctors who deliberately hasten the death could face the prospect of life imprisonment; see J. Harvard, 'The Legal Threat to Medicine' (1982) 284 *B.M.J.* 612, 613.

¹⁰² This has been confirmed by conversations with public prosecutors in Australia. For more detailed discussion regarding the exercise of prosecutorial discretion, see below, 129-133.

¹⁰³ P. Key, 'Euthanasia: Law and Morality' (1989) 6 *Auckland U.L.Rev.* 225, 230; Williams, *The Sanctity of Life and the Criminal Law*, 291.

¹⁰⁴ For example, *People v Sander* (unreported) *N.Y. Times* 10 March, 1950; *People v Montemarano* (unreported) (1974) Nassau County Court, (N. Y.) referred to above, 124-125. Moreover, in practice difficulties may be encountered in finding a doctor who is willing to give evidence against another doctor, particularly in criminal proceedings.

juries have tended to acquit in circumstances where the evidence and the judge's direction leave them with no legal reason for doing so.¹⁰⁵ It is in fact quite a remarkable that the recent conviction for attempted murder of Dr Cox in the United Kingdom is virtually the first case in which a doctor has been convicted for having taken steps to end the life of a suffering patient.¹⁰⁶

Mercy Killing Cases in the Criminal Justice System

Although there have been notably few cases of doctors being prosecuted for performing active euthanasia or assisted suicide, there have been quite a number of prosecutions outside the medical context. In Australia, the United States and the United Kingdom, many cases have arisen involving 'mercy killings' or suicide assistance by non-medical persons, be it a spouse, relative or friend of the deceased.¹⁰⁷ In the overwhelming majority of cases, such offenders are dealt with extremely leniently by the criminal justice system, even though the criminal law has clearly been violated.

Whilst there is considerable similarity in the overall approach taken to mercy killing cases in these countries, there are also significant differences stemming from discrepancies with respect to possible jury verdicts and sentencing options.¹⁰⁸ For effective coverage of the law in practice with respect to mercy killing in Australia, the United States and the United Kingdom, it is therefore necessary to examine each of the jurisdictions separately.

Australia

A review of mercy killing cases in Australia cases reveals that a number of mechanisms within the criminal justice system have been invoked to temper the rigours of the criminal law with respect to homicide and assisted suicide.

Prosecutorial Discretion

Criminal law in Australia comes within the jurisdiction of the States and Territories and each jurisdiction also has its own prosecutorial division. An important feature of the exercise of prosecutorial powers is the existence of prosecutorial discretion.¹⁰⁹ None of the prosecutorial

¹⁰⁵ Perhaps the most remarkable case is that of Dr Sander in which the jury acquitted the defendant even though he had entered on the medical record of the deceased notes to the effect that he had deliberately injected air into the vein of the patient and that the patient had died a short time later; *People v Sander* (unreported) *N.Y. Times* 10 March, 1950. See above, 124.

¹⁰⁶ The only exception has been in cases where the doctor had a familial connection with the deceased and had pleaded guilty to the charge; e.g. the case of *People v Hassman* (unreported) *N. Y. Times* 20 Dec. 1986 discussed above, 125.

¹⁰⁷ Reference will also be made where relevant to mercy killing cases arising in Canada and New Zealand. Some of the cases considered below were not cases of voluntary euthanasia performed at the request of the patient, but involved non-voluntary euthanasia. Although these cases are considered together, it is by no means intended to suggest that cases of non-voluntary euthanasia can simply be equated with voluntary euthanasia.

¹⁰⁸ For example, the defence of temporary insanity which is available in the United States and which has proved to be of considerable relevance in the context of family mercy killings, is not available in Australia or the United Kingdom.

¹⁰⁹ For discussion of the nature, source and exercise of prosecutorial discretion, see T. Hetherington, *Prosecution and the Public Interest* (1989).

departments in Australia have an official policy with regard to the treatment of mercy killing or active euthanasia, nor do they have prosecution guidelines specifically dealing with these issues.¹¹⁰ There are, however, general guidelines and criteria governing the decision to prosecute,¹¹¹ and any decision as to whether a prosecution should be instituted or continued in a mercy killing case are made having regard to these criteria.

The initial consideration in the exercise of prosecutorial discretion is whether the evidence is sufficient to justify the institution or continuation of a prosecution.¹¹² A prosecution should not be commenced if there is no reasonable prospect of a conviction being secured. In cases of mercy killing there is potential for a jury to be motivated towards an acquittal out of sympathy for the defendant notwithstanding the strength of the prosecution case. However, the guidelines make it clear that any such potential should be disregarded by the prosecutor in assessing the prospects of securing a conviction on the available evidence. The criteria state that in indictable matters, this assessment is to be made on the assumption that the jury will act in an impartial manner and in accordance with its instructions.¹¹³ Provided the available evidence satisfies the test of evidential sufficiency, it is then appropriate for the prosecutor to consider whether the public interest requires a prosecution to be pursued.¹¹⁴ The criteria set out a number of factors which may be relevant in determining this question, and it is at this stage that the prosecution may validly take into account the special circumstances of a mercy killing case. Factors which are relevant in determining the public interest requirement, and which may be of particular significance in such cases, include the existence of any mitigating circumstances, the age and physical health of the alleged offender or victim, whether the consequences of any resulting conviction would be unduly harsh and oppressive, and the likely outcome in the event of a finding of guilt having regard to the sentencing options available to the court.¹¹⁵ The guidelines go on to make it clear that although there may be mitigating factors present in a particular case, often the proper decision will be to prosecute and for those factors to be put to the court for the purposes of sentencing by way of mitigation.¹¹⁶

In practice, the mercy killing cases which have arisen in Australia have almost invariably been prosecuted. In discussions with the writer, prosecutors have confirmed that the circumstances would have to be quite exceptional for a decision to be made not to prosecute an offender, particularly having regard to the gravity of the offence. However, apart from the decision not to prosecute, there are a number of other ways in which prosecutorial discretion may be manifest including the discontinuance

¹¹⁰ This and the information which follows, stems from interviews conducted by the writer with persons from the office of the Director of Public Prosecutions in each Australian jurisdiction (with the exception of the Northern Territory in respect of which inquiries were conducted by correspondence.)

¹¹¹ In the interests of consistency in the exercise of prosecutorial discretion uniform guidelines have been formulated by Directors of Public Prosecution and senior Crown Prosecutors for application throughout Australia. See the Office of the Director of Public Prosecutions, Victoria, *Annual Report* 1989/90, 55-66.

¹¹² *Id.* 56.

¹¹³ *Id.* 57.

¹¹⁴ *Ibid.*

¹¹⁵ *Id.* 59-60.

¹¹⁶ *Id.* 61.

of a prosecution, prosecuting for a lesser charge, and the acceptance of a plea of guilty for a lesser offence.¹¹⁷

Prosecution Discontinued

There have been cases where, in the exercise of prosecutorial discretion, a decision has been taken not to proceed with a prosecution.¹¹⁸ One such case arose in the Australian Capital Territory in 1983 when the then Commonwealth Attorney-General, Senator Gareth Evans,¹¹⁹ decided not to proceed with a charge of murder against a woman who had allegedly killed her sister who had been suffering from a terminal illness and had expressed a wish to die.¹²⁰ The murder charge arose following a coronial inquiry into the death in which a *prima facie* case of murder was found to have been established against the defendant. In explaining the reasons for the decision not to proceed with the prosecution, Senator Evans stated that the evidence against the defendant was largely circumstantial and it was considered that a jury would be unlikely to convict.¹²¹ However, he emphasised that the decision was based wholly on the exceptional circumstances of the case, and should not be taken as signalling any particular approach to cases of this kind.¹²² In furtherance of this decision not to proceed with the prosecution, the Crown filed a bill of *nolle prosequi* in the Australian Capital Territory Supreme Court.¹²³

Another example of a discontinued prosecution can be found in the Tasmanian case of *R v Baker*.¹²⁴ The defendant, Reginald Baker, was charged with murder as a result of shooting his sick wife in the forehead with a .22 calibre rifle. The deceased's health had been failing for some time as a result of a number of strokes, and in the months preceding the incident, it had significantly deteriorated rendering the deceased incapable of caring for herself. In a statement made to the police by the defendant, the

¹¹⁷ In addition to the circumstances discussed below, prosecutorial discretion may also arise with regard to the issue of bail. Significantly, in quite a number of mercy killing cases, the defendants were released on bail notwithstanding the seriousness of the charges against them; e.g. *R v Baker* (unreported) the *Mercury* 5 Dec. 1972, 6 Dec. 1972; *R v Johnstone* (unreported) 21 Jan. 1987, S.C. S.A. Whilst the determination of bail lies at the discretion of the court, the prosecution would usually be called upon to present submissions to the court with regard to the matter. It is, therefore, quite possible for the Crown not to oppose bail in genuine cases of mercy killing, and interviews with prosecutors have confirmed that this would, in some instances, be the appropriate course.

¹¹⁸ It should be noted that in most Australian jurisdictions, proceedings are initially commenced by the police and the prosecution only becomes involved after the defendant has been committed for trial. It is possible that proceedings are dismissed at the committal stage; e.g. *Police v Caves* (unreported) 21 Sept. 1987, Newcastle L.C., N.S.W. in which Stewart Caves was prosecuted for the manslaughter of his wife. The deceased had, for a number of years, suffered unrelievable pain following an unsuccessful dental procedure. In a deliberate plan to take her own life, she had, to the knowledge of her husband, taken a lethal dose of drugs and her husband had taken no action to prevent her from doing so. At the committal hearing the Magistrate found that the police had established a *prima facie* case against the defendant on the manslaughter charge but held that there was no real chance or prospect that a jury would convict him and accordingly ordered that the defendant be discharged.

¹¹⁹ Since the case arose in the A.C.T. prior to the establishment of the Commonwealth Director of Public Prosecutions in March 1984, the discretion whether to prosecute lay with the Commonwealth Attorney-General.

¹²⁰ Due to a suppression order made by the court, the name of the defendant in this case may not be published.

¹²¹ Law Reform Commissioner, Victoria, Working Paper No. 8, *Murder: Mental Element and Punishment*, (1984) 25 (hereafter referred to as Victorian Law Reform Commissioner Working Paper.)

¹²² Press release by the Attorney-General, Senator Gareth Evans, 11 July 1983.

¹²³ (Unreported) the *Canberra Times* 12 July 1983.

¹²⁴ (Unreported) the *Mercury* 5 Dec. 1972, 6 Dec. 1972.

defendant indicated that the deceased had a dread of being placed in a nursing home and that in the light of her worsening condition, he had summoned the courage to spare her from any more unhappiness and pain by taking her life. The defendant pleaded not guilty to the charge. Following committal proceedings, the defendant was committed for trial,¹²⁵ but in view of the medical evidence presented at committal proceedings which had raised some doubt as to the cause of death,¹²⁶ the Crown decided not to file an indictment, and the defendant was discharged.¹²⁷ As noted above,¹²⁸ the sufficiency of evidence is an important consideration in the exercise of prosecutorial discretion, and having regard to the equivocal medical evidence it is possible that a reasonable jury, properly instructed, would have had a reasonable doubt as to the cause of death. However, having regard to the tragic circumstances of the case, the conclusion appears inescapable that considerations of sympathy for the defendant also played some role in the interpretation of the medical evidence.¹²⁹

Prosecution for Lesser Charge

Another way in which prosecutorial discretion may be manifest in a genuine mercy killing case is for the prosecution to proceed with a lesser charge.¹³⁰ This occurred in the case of *R v Austen*¹³¹ in which the defendant, an elderly man of outstanding character, was indicted for manslaughter rather than murder for the killing of his wife who had been suffering from Alzheimer's disease. From discussions with Crown Prosecutors, it would appear, however, that this would normally only be done in circumstances where there is sound justification for reducing the charge.¹³²

Acceptance of Plea of Guilty by the Crown for Lesser Offence

In cases where prosecution for the more serious offence is set to proceed the Crown may be prepared to accept a plea of guilty from the defendant to a lesser offence in full satisfaction of the charge. Whilst the decision to accept a plea for a lesser offence lies within the discretion of the prosecution,¹³³ there are general principles and in some jurisdictions, specific guidelines¹³⁴ which guide the exercise of this discretion. According to accepted prosecutorial practice, there must be good justification before a decision is taken to accept a lesser plea.¹³⁵ A plea should not be accepted unless it reasonably reflects the nature of the criminal conduct of the defendant and provides an adequate basis

¹²⁵ Notice of Committal dated 16 Feb. 1973.

¹²⁶ On the evidence, it was impossible to rule out the possibility that the deceased was already dead at the time the shot was fired.

¹²⁷ Criminal Court, 7 May 1973 before Neasy J.

¹²⁸ See above, 130.

¹²⁹ An informal conversation with a former member of the Tasmanian Director of Public Prosecutions office has confirmed that this was in fact the case.

¹³⁰ A reduced charge may possibly be the result of plea-bargaining between the prosecution and the offender.

¹³¹ (Unreported) 5 March 1990, S.C. N.S.W.

¹³² For example, in the case of *R v Austen* (unreported) 5 March 1990, S.C. N.S.W., some doubt had been raised as to the psychiatric condition of the defendant.

¹³³ See *R v Brown* (1989) 17 N.S.W.L.R. 472 where it was held that the prosecution has a wide discretion to present and accept a plea to a lesser charge, notwithstanding that uncontested evidence establishes the commission of a more serious offence. The court does, however, have a discretion whether to accept a plea, although this is rarely exercised in practice; see Hetherington, 168.

¹³⁴ For example, Office of the Director of Public Prosecutions, Victoria, *Annual Report* 1989/90, 63-66.

¹³⁵ For example, having regard to the likelihood of conviction or doubts with regard to the evidence or the mental state of the defendant.

upon which a court can impose an appropriate sentence.¹³⁶ Where there is a plea of guilty to a lesser offence the Crown may, for the purposes of sentencing, agree to proceed on an accepted factual basis favourable to the defendant.

The Victorian case of *R v Larkin*¹³⁷ illustrates the Crown's role in accepting a plea to a lesser offence in full satisfaction of the charge. In that case, the defendant, a nurse, was initially charged with the murder of her lover - a manic depressive, who had, on a number of occasions, threatened to commit suicide. The deceased had taken an overdose of tablets whilst the defendant was at work. When the defendant returned from work the deceased once again expressed his wish to die and attempted to inject himself with a fatal dose of insulin. The defendant then responded to her lover's plea and administered the fatal injection. The defendant subsequently pleaded guilty to a charge of aiding and abetting suicide under the *Crimes Act 1958* (Vic.) and the Crown accepted this plea. Another case in point is that of *R v Thompson*.¹³⁸ The charges against Thompson arose as a result of a confession that he had made to the police concerning the murder of his father in 1969, some 12 years earlier. The defendant's father had been suffering from Parkinson's disease for several years. He had been in poor physical and mental condition, but had declined to go into a nursing home. The defendant had employed a nurse to look after him, but he often did the nursing of his father himself. On Christmas day 1969, the defendant had killed his father by placing a plastic bag over his head. Thompson pleaded not guilty to the charge of murdering his father, but guilty to the lesser charge of manslaughter and this plea was accepted by the Crown.¹³⁹

The Crown's role in accepting a plea of guilty from the defendant to a lesser offence in full satisfaction of the charge is, in practice, likely to be particularly relevant in those jurisdictions where there is still a mandatory sentence of life imprisonment for murder.¹⁴⁰ For the purpose of these jurisdictions, if the Crown accepts a plea of guilty to a charge of manslaughter or assisted suicide rather than murder, the possibility is thereby opened up for discretion in the sentencing of the defendant.¹⁴¹

¹³⁶ *Id.* 63.

¹³⁷ (Unreported) 14 April 1983, S.C. Vic.

¹³⁸ (Unreported) 25 Nov. 1981, S.C. N.S.W. For further examples of Australian cases in which the Crown has accepted a plea for a lesser offence in a mercy killing case, see *R v Robert-Jones* (unreported) 6 Aug. 1987 S.C. N.S.W and *R v Thiel* (unreported) 27 Sept. 1990, S.C. N.S.W.

A recent New Zealand prosecution, *R v Ruscoe*, illustrates the same proposition. In 1991 Warren Ruscoe was charged with the murder of his long-time friend Gregory Nesbit who had become a tetraplegic following an accident. Ruscoe had confessed to police that he had given the deceased an overdose of tablets and had then smothered him with a pillow. The charge of murder was subsequently withdrawn and the prosecution accepted a plea of guilty to the lesser charge of aiding and abetting suicide; *Evening Post* 21 March 1992.

¹³⁹ This was done largely on the basis of a psychiatric report which suggested diminished responsibility on the part of the defendant.

¹⁴⁰ Life imprisonment is still the mandatory sentence for murder in the Northern Territory, Queensland, South Australia, Tasmania and Western Australia. As a result of legislative reform, the sentence for murder is now discretionary in the Australian Capital Territory, New South Wales and Victoria. The position in the Australian Capital Territory is governed by s. 442(1) of the *Crimes Act 1900* (N.S.W.) as amended by s. 23 of Ordinance No. 11 in 1963. For the position in New South Wales and Victoria, see s. 19 *Crimes Act 1900* (N.S.W.) (as amended in 1982) and s. 3 *Crimes Act 1958* (Vic.) (as amended in 1986) respectively.

¹⁴¹ In cases of manslaughter or assisted suicide the courts have always had a discretion with regard to sentence.

Jury Acquittals

Juries have considerable discretion in the verdicts they bring in, since they are general verdicts only, and juries do not have to give reasons for their decisions.¹⁴² Of those cases which have proceeded to trial, a significant proportion have resulted in the acquittal of the defendant by the jury often against the weight of the evidence. Here too, in practice, jury acquittals may be particularly relevant with regard to proceedings for murder in jurisdictions where there is still a sentence of mandatory life-imprisonment.¹⁴³

One example of a jury acquittal is the case of *R v Meares and Wanless*¹⁴⁴ in which charges arose out of the fatal shooting of a 54 year old cancer victim. The deceased, Mervyn Meares, had been in severe pain from terminal cancer and had apparently wanted to end his life. Mr Wanless, a 45 year old invalid pensioner, and a close friend of the deceased, was charged with the murder. The deceased's wife, Mrs Meares, a 58 year old pensioner, was charged with having solicited Wanless to murder her husband. Both had pleaded not guilty to the charges. Notwithstanding the admission into evidence of an incriminating police record of interview given by the defendant Meares, her defence counsel succeeded with a 'no case to answer' application on the grounds that there was insufficient evidence of communication by his client with the co-defendant with the object of soliciting the murder. Justice Maxwell accordingly directed the jury to find the defendant Meares not guilty of the charge of having solicited the co-defendant Wanless to murder her husband. The case did, however, proceed against the co-defendant, Wanless. The Crown case relied on both motive and opportunity in that Wanless felt compassion for his sick friend and had visited him the day the shooting had occurred. Further, the Crown alleged that the deceased had continually begged for assistance to put an end to his suffering. There was also evidence connecting Mr Wanless with the weapon which had been used in the killing. Wanless gave evidence that he had visited the deceased that day but that he had not killed his friend. Despite the strength of the prosecution case, the jury found Wanless not guilty of the charge and he was acquitted.

Another case where the jury acquitted the defendant against the evidence, was *R v Austen*.¹⁴⁵ As noted above,¹⁴⁶ the manslaughter charges in this case arose out of the killing of the deceased, a sufferer of Alzheimer's disease, by her husband. The defendant had been caring for his wife for a number of years but her condition had deteriorated and he was finding it increasingly difficult to cope with the situation. Evidence for the Crown was that he had suffocated his wife by putting his hand over her nose and a handkerchief in her mouth. The defendant had pleaded not guilty to the charge but did not dispute the evidence that he had suffocated his wife. In his evidence he simply said that he could not really believe that he had done it or explain why or how. Following a plea by counsel for

¹⁴² I. Temby, 'Euthanasia - Is It Murder?' (1988) 21 *A.J.F.S.* 2, 16.

¹⁴³ See above, n. 140.

¹⁴⁴ (Unreported) July 1989, Newcastle S.C., N.S.W.

¹⁴⁵ (Unreported) 5 March 1990, S.C. N.S.W.

¹⁴⁶ See above, 132.

the defendant for a merciful verdict, (without really putting any legal basis for such a verdict), the jury returned a verdict of not guilty.

There have also been mercy killing cases in Australia where the jury has found the defendant guilty but has made strong recommendations for leniency in the treatment of the defendant.¹⁴⁷

Leniency in Sentencing

In cases involving conviction of the offender, (mostly arising from pleas of guilty)¹⁴⁸ the courts, have generally shown great leniency with respect to the sentencing, at least in those jurisdictions where the court has had a discretion to do so.¹⁴⁹

For example, in the case of *R v Thompson*¹⁵⁰ noted above,¹⁵¹ in which the Crown had accepted the defendant's plea of guilty to the lesser offence of manslaughter in respect of a deliberate killing, Justice Hunt deferred passing sentence and placed Thompson on a \$5,000 bond to be of good behaviour for 5 years.¹⁵² His Honour then went to great lengths to justify this decision. Whilst recognising that some people in the community would object to his decision, and regard it as 'weakly merciful', he felt that in the circumstances of the evidence disclosed, a term of imprisonment would serve no benefit to the prisoner or to the community. Justice Hunt accepted that the defendant's dominant motive in acting as he did was to put his father out of his misery. He also accepted that the matter was only brought to light by the defendant's own confession, which was a strong indication of his contrition. His Honour said that he had taken into consideration that the defendant had no relevant prior record as well as his position and acceptance in the community. Furthermore, the judge said that he could not imagine that Thompson would offend again.

Another striking example of judicial leniency in sentencing can be found in the case of *R v Johnstone*¹⁵³ in which the defendant had pleaded guilty to the murder of his mentally ill wife who had begged him to assist her to die. Justice Bollen of the South Australian Supreme Court, said that he accepted that the defendant's act of killing was not done out of desire for personal benefit but out of a deep compassion and love for his wife. His Honour explained that whilst he was required by statute to pass the mandatory sentence of life imprisonment for the crime of murder, the defendant was entitled to leniency in the fixing of the non-parole period. Justice Bollen was of the view that in all the circumstances, it was not appropriate to sentence the defendant to any real term of imprisonment and proceeded to fix a non-parole period of only 10 days, to be calculated from the date when the defendant

¹⁴⁷ For example, *R v Tait* (unreported) 13 June 1972, S.C. Vic.

¹⁴⁸ See, for example *R v Larkin* (unreported) 14 April 1983, S.C. Vic.; *R v Thompson* (unreported) 25 Nov. 1981, S.C. N.S.W.; *R v Kelly* (unreported) 12 May 1989, S.C. Qld; *R v Johnstone* (unreported) 21 Jan. 1987, S.C. S.A. There have also been cases where conviction resulted following a plea of not guilty; e.g. *R v Tait* (unreported) 13 June 1972, S.C. Vic.

¹⁴⁹ See above, n. 140.

¹⁵⁰ (Unreported) 25 Nov. 1981, S.C. N.S.W.

¹⁵¹ See above, 133.

¹⁵² Section 24 of the *Crimes Act* 1900 (N.S.W.) provides for a maximum sentence of 25 years imprisonment for the offence of manslaughter.

¹⁵³ (Unreported) 21 Jan. 1987, S.C. S.A.

first came before the court. The Crown appealed against sentence on the grounds that the non-parole period was manifestly inadequate. Although the Court of Criminal Appeal found that the judge's sentencing discretion had miscarried, the court was, in all the circumstances, not prepared to interfere with the sentence which had been imposed.¹⁵⁴

A further instance of judicial leniency towards mercy killers with respect to sentence can be found in the cases of *R v Kelly*¹⁵⁵ and *R v Hollinrake*¹⁵⁶ which involved very similar circumstances. In the case of *R v Kelly* the defendant, an 81 year old man pleaded guilty to the attempted murder of his wife who had suffered several strokes. There was evidence before the Queensland Supreme Court that the deceased had been an invalid for some years and the defendant had dutifully taken care of her. However, after she suffered her fourth stroke resulting in a marked deterioration of her condition, the defendant shot her to put her out of her misery. She survived the shooting but died some months later from coronary artery disease. Justice Ryan sentenced the defendant to three years of probation. In passing sentence, he referred to the advanced age of the prisoner, his good background, his close relationship with his wife, his perception of her condition as one of misery, and his depressed state at the time and concluded that in those circumstances, a custodial sentence was not demanded and would not serve any useful purpose.

In the Victorian case of *R v Hollinrake* the defendant, 80 years of age, was charged with the attempted murder of his 79 year old wife who had been his partner for 51 years. Mrs Hollinrake had had a stroke which affected her vision and speech and left the right side of her body paralysed. The defendant had slit the wrist of his wife's paralysed right arm while she was in hospital.¹⁵⁷ He then went home and tried to kill himself by cutting his wrists and forearm in the shower. A note written by the defendant, informing staff of a euthanasia and suicide pact between the couple, was found beside Mrs Hollinrake. His wife was revived by medical staff and his own suicide attempt was foiled when a visitor unexpectedly arrived at his home. The defendant pleaded guilty in the Victorian Supreme Court to the charge of attempted murder. He was placed on a three year good behaviour bond. In sentencing the defendant, Justice Coldrey said that the circumstances of the case were truly tragic. His Honour accepted that the defendant's motivation in attempting to kill his wife stemmed from his love and compassion for her. There was also evidence before the court that the couple had previously discussed the issue of mercy killing. Both had considered the prospect of being dependent in a nursing home totally unacceptable and each had pledged to act to end the life of the other in such circumstances. The judge said that mercy killing could not be accepted or condoned by the courts, and that it was the court's duty to uphold the sanctity of life. However, he did not believe that the community would want retribution against the defendant in this exceptional case. Nor did he think that specific deterrence

¹⁵⁴ *R v Johnstone* (1987) 45 S.A.S.R. 482. In support of this conclusion, Chief Justice King referred to the well established principle that in a Crown appeal, an error in the sentencing process does not lead inevitably to intervention by the court; 485.

¹⁵⁵ (Unreported) 12 May 1989, S.C. Qld.

¹⁵⁶ (Unreported) 29 June 1992, S.C. Vic.

¹⁵⁷ In the evidence before the court it was pointed out that the defendant had chosen to cut the wrist of her paralysed right arm in the belief that this would cause her no pain.

needed to be given weight in the circumstances of this case. Although acknowledging the court's duty in sentencing offenders to attempt to deter others from embarking on similar behaviour, his Honour was of the view that given the rarity of this type of offence, the principles of general deterrence did not need to be accorded prominence. Justice Coldrey said that the courts must dispense justice, but in the circumstances of this case, that justice may be tempered with mercy. In all the circumstances, his Honour came to the conclusion that a sentence of imprisonment was not warranted.

Similarly, in cases of assisted suicide, the courts have shown considerable leniency. The courts' approach is illustrated by the Victorian case of *R v Larkin*¹⁵⁸ (discussed above¹⁵⁹). Following a plea of guilty to a charge of aiding and abetting suicide under the *Crimes Act* 1958 (Vic.) (carrying a maximum penalty of 14 years), the defendant was placed on a three year good behaviour bond with the condition that she attend psychiatric counselling.¹⁶⁰ Justice Nicholson of the Victorian Supreme Court observed that in the circumstances of the case, there was no requirement that the sentence be retributive, nor were considerations of general or special deterrence of relevance, the offence being so unusual and the defendant having acted from the highest of motives, 'if misguided'.¹⁶¹

The New South Wales case of *R v Den Heyer*¹⁶² also serves to illustrate the leniency shown by the courts in cases of this kind. The deceased was suffering from terminal cancer and was experiencing severe pain. He had, on a number of previous occasions, attempted to commit suicide. The defendant, 28 years of age, was charged with aiding and abetting the suicide of his father by supplying the gun with which the father had shot himself. The defendant had pleaded guilty to the charge. Justice Court was firmly of the view that none of the principal objectives of sentencing called for the imposition of a custodial sentence in this case and proceeded to sentence the defendant to the rising of the court.¹⁶³

Role of Prosecution in Sentencing

Although sentencing the offender is the responsibility of the court, it should be noted that the prosecution may have some role to play in making submissions with regard to sentence. It is not the practice of the prosecution in Australia to routinely address the court with regard to sentence. Rather,

¹⁵⁸ (Unreported) 14 April 1983, S.C. Vic.

¹⁵⁹ See above, 133.

¹⁶⁰ *Ibid.*

¹⁶¹ *Ibid.*

¹⁶² (Unreported) 28 Sept. 1990, Paramatta D.C., N.S.W. Note also *R v Savage* (unreported) 27 March 1992 in which the defendant had pleaded guilty to aiding his terminally ill wife to commit suicide pursuant to a suicide pact. The defendant was ordered by the court to perform 200 hours community service; the *Australian* 28 March 1992.

Examples of leniency in sentencing in mercy killing cases can also be cited from New Zealand. For example, *R v Ruscoe*, noted above, n. 138, in which the defendant had pleaded guilty to a charge of aiding and abetting the suicide of his paralysed friend. Under s. 179 of the New Zealand *Crimes Act* 1961 the offence carries a maximum of 14 years imprisonment. The defendant was sentenced to imprisonment for nine months. In an appeal against sentence, the Court of Appeal quashed the original sentence and substituted a sentence of one years' supervision. The court held that in exceptional cases of aiding suicide, a non-custodial sentence is appropriate. 20 March 1992, C.A. N.Z.

Note also the case of *R v Novis* (unreported) in which the defendant was charged with the murder of his terminally ill father. The jury reduced the conviction to manslaughter and the defendant was sentenced to 12 months supervision; *Waikato Times* 6 Feb. 1988.

¹⁶³ *Ibid.* Section 31C of the *Crimes Act* 1900 (N.S.W.) provides for a maximum sentence of 10 years imprisonment for the offence of aiding and abetting suicide.

the function of the Crown prosecutor is seen as preventing the judge from falling into appealable error and to provide assistance to the court where that is specifically sought.¹⁶⁴ The special mitigating circumstances of mercy killing cases may, however, justify the Crown in making submissions with regard to sentence indicating the Crown's acquiescence in the lenient treatment of the offender, and this is in fact one of the many ways in which prosecutorial discretion may be exercised in favour of the defendant.¹⁶⁵ A useful illustration is the case of *R v Kelly*¹⁶⁶ noted above,¹⁶⁷ involving a conviction for attempted murder. Counsel for the defendant sought a non-custodial sentence and the prosecution accepted that this was appropriate in view of the very special circumstances of the case.

Parole Boards and the Exercise of Executive Clemency

As noted earlier, in some Australian jurisdictions, judges have little discretion with regard to the sentence they can impose, particularly with regard to the crime of murder.¹⁶⁸ As a result, there have been a number of mercy killing cases where the courts have had no option but to pass the mandatory sentence notwithstanding the special mitigating circumstances in such cases. In some of the earlier cases decided while the death penalty still applied, this effectively required passing the mandatory death sentence for murder.¹⁶⁹ However, in all of these cases where a mandatory sentence was imposed, the severity of the sentence was mitigated by the exercise of executive clemency¹⁷⁰ and/or favourable determinations of the parole bodies.¹⁷¹ One widely publicised example is the 1964 Western Australian case of Dr Maurice Benn who had been sentenced to the mandatory death penalty for the mercy killing of his mongoloid son.¹⁷² His sentence was subsequently commuted to imprisonment with hard labour for ten years and in December 1968 he was released on parole.¹⁷³

There have also been a number of mercy killing cases in South Australia and Victoria in which the mandatory death sentence was passed but was then commuted to life imprisonment.¹⁷⁴ In each of

¹⁶⁴ See, for example, N.S.W. Director of Public Prosecutions, *Prosecution Policy and Guidelines* (1987) 5-6.

¹⁶⁵ Where the defendant is convicted of murder, submissions with regard to sentence would only be appropriate in those jurisdictions which do not have a mandatory sentence; see above, n. 140. There is a trend in Australia towards statutory provision allowing submissions on sentence from the prosecution; e.g. s. 386 of the *Criminal Code* 1924 (Tas.) as amended by the *Criminal Code Amendment (Addresses on Sentences) Act* 1987 (Tas.).

¹⁶⁶ (Unreported) 12 May 1989, S.C. Qld. See also *R v Hollinrake* (unreported) 29 June 1992, S.C. Vic. (discussed above, 136-137) as a further illustration of this approach.

¹⁶⁷ See above, 136.

¹⁶⁸ See above, 140.

¹⁶⁹ For example, *R v Benn* (unreported) 2 April 1964, S.C. W.A.; *R v Wright* (unreported) 3 July 1972, S.C. S.A.; *R v Cullen* (unreported) 25 March 1976, S.C. S.A.; *R v Tait* (unreported) 13 June 1972, S.C. Vic.

¹⁷⁰ The prerogative of mercy is one of the reserve powers of the Crown but may be abolished, restricted or regulated by statute; K. Warner, *Sentencing in Tasmania* (1991) 5.

¹⁷¹ All Australian jurisdictions have a system of parole. Parole also exists in the United Kingdom, Canada and some United States jurisdictions.

¹⁷² (Unreported) 2 April 1964, S.C. W.A.

¹⁷³ *The West Australian* 3 Dec. 1968. There had been widespread community support for Dr Benn's release, including signed petitions seeking his early release; see, for example, the *West Australian* 23 Dec. 1964.

¹⁷⁴ *R v Wright* (unreported) 3 July 1972, S.C. S.A.; *R v Cullen* (unreported) 25 March 1976, S.C. S.A.; *R v Tait* (unreported) 13 June 1972, S.C. Vic.

these cases the defendant served a relatively short prison term before being released on parole.¹⁷⁵ However, care must be taken not to overstate the significance of the foregoing cases. Whilst these cases do provide some evidence of leniency, at least in so far that the death sentence was commuted to life imprisonment, of which the defendants only served a few years, there are grounds to suggest that the treatment of these cases was by no means exceptional. The death sentence was in fact commuted in the majority of cases and it was not unusual for a convicted murderer to be released on parole after serving a few years of the life sentence.¹⁷⁶

In contrast to these earlier cases, a more significant illustration of leniency is to be found in the South Australian case, *R v Johnstone*¹⁷⁷ referred to above.¹⁷⁸ In this case, a token non-parole period of 10 days was imposed after the mandatory life sentence for murder had been handed down and Johnstone was in fact released on parole a few days after the expiration of this period.¹⁷⁹

United States

In the United States, there have, over the years, been many cases of mercy killing which have come to the attention of the criminal justice system¹⁸⁰ and a review of these cases reveals a similar pattern of leniency.¹⁸¹ These cases illustrate that under the law in the United States, there are a number of ways in which the full rigours of the criminal law can be avoided in circumstances where the mercy killing attracts widespread sympathy and approval and in a large proportion of cases, mercy killers have in fact completely escaped criminal liability.

Refusal by Grand Jury to Indict

Quite a number of American States have provision under legislation for a 'grand jury'. The role of the grand jury is to hold a preliminary hearing into the matter to determine whether there is sufficient evidence for the matter to go to trial.¹⁸² This procedure has clearly proved favourable to some

¹⁷⁵ In each case the defendant served 5-6 years in prison. (Verbal communication with an officer of the Adult Parole Board, South Australia, September 1990.)

¹⁷⁶ Verbal communication with an officer of the Adult Parole Board, South Australia, September 1990.

¹⁷⁷ (Unreported) 21 Jan. 1987, S.C. S.A.

¹⁷⁸ See above, 135-136.

¹⁷⁹ The discrepancy in dates was due to a delay in the processing of the necessary paperwork. The minimum period of parole for a prisoner serving a life sentence was imposed (3 years.) (Verbal communication with an officer of the Adult Parole Board, South Australia, September 1990.)

¹⁸⁰ A number of commentators have documented these cases; e.g. Baugham, Bruha and Gould, 1213-1215; J. Sander, 'Euthanasia: None Dare Call it Murder' (1969) 60 *J.Crim.L., Criminology & Police Science* 351, 355-357; L. Glantz, 'Withholding and Withdrawing Treatment: The Role of the Criminal Law' (1987-8) 15 *Law Med. & Health Care* 231, 232-235; V. Gilbreath, 'The Right of the Terminally Ill to Die with Assistance if Necessary' (1986) 8 *Crim.Just.J.* 403, 416; Russell, 256-260, 391-392; Humphry and Wickett, especially at 17-20, 91-92, 137-150; Humphry, *Compassionate Crimes, Broken Taboos*.

¹⁸¹ Similar developments have also occurred in Canada although the range of possible outcomes is somewhat circumscribed in comparison with the United States since Canadian law does not allow for the defence of temporary insanity. There have, nevertheless, been cases where juries have acquitted the mercy killer, albeit completely against the evidence. See, for example, the case referred to by L. Schiffer, 'Euthanasia and the Criminal Law' (1985) 42 *U. Toronto Fac.L.Rev.* 93, 95 where a couple killed their pain-stricken son with car exhaust fumes after they could no longer bear his anguished cries. Although the couple had made a confession to the police, they were found not guilty of murder.

¹⁸² Some analogy could be drawn between the grand jury in the United States and committal proceedings in Australia.

defendants in cases of mercy killing. In a number of instances, the grand jury has refused to indict, thereby terminating proceedings against the mercy killer. For example, in 1939, Harry Johnson was arrested for asphyxiating his cancer-stricken wife. The grand jury refused to indict on the basis that he was 'temporarily insane' at the time of the act.¹⁸³ Similarly, in 1983, a grand jury in Florida refused to indict a 79 year old man, Hans Florian who had killed his wife by shooting her in the head. The deceased had been suffering from Alzheimer's disease. Although Mr Florian readily admitted killing his wife, the grand jury refused to return an indictment.¹⁸⁴

Conviction for Lesser Offence

In other cases, notwithstanding that the mercy killer was, on the facts, clearly guilty of murder, a conviction for a lesser offence has resulted. This may follow from a reduction in the offence charged by the prosecution¹⁸⁵ or by virtue of a sympathetic jury seeking to avoid liability for murder as was the case in *People v Repouille*. The defendant in that case had chloroformed his 13 year old imbecile son.¹⁸⁶ He was indicted for first-degree murder but the jury found him guilty of second-degree manslaughter, and he was subsequently freed on a suspended sentence of 5-10 years. This verdict was completely inconsistent with the facts since manslaughter in the second-degree presupposes that the killing had not been deliberate.¹⁸⁷

Acquittals

In circumstances where the mercy killer pleads not guilty to the offence, there are many instances of outright acquittals¹⁸⁸ or acquittals on the grounds of temporary insanity. A well-known case of a court (as distinct from the jury) acquitting a defendant occurred in *People v Werner*.¹⁸⁹ The defendant had suffocated his crippled and bedridden wife after he had been informed that they were both to be moved to a nursing home. Although a plea of guilty to the crime of manslaughter had already been accepted by the court,¹⁹⁰ after hearing evidence in relation to sentence, of the defendant's love and devotion to his wife, the judge suggested that the defendant withdraw his plea of guilty. The defendant was subsequently acquitted on the basis that a jury would not be inclined to convict in these circumstances.¹⁹¹

¹⁸³ *People v Johnson* (unreported) *N.Y. Times* 12 Oct. 1938, *N.Y. Times* 19 Oct. 1938.

¹⁸⁴ *People v Florian* (unreported) *San Francisco Chronicle* 4 April 1983. Note also the case of *People v Reinecke*, a 1967 Illinois case in which the jury refused to indict the defendant who had strangled his 74 year old wife who had been suffering from cancer; Russell, 259.

¹⁸⁵ For example, *People v Hoffman* (unreported) (1978) where, through plea-bargaining, the charge for first-degree murder was reduced to manslaughter (Humphry and Wickett, 143) *People v Kacherian* (unreported) (1981) charge of murder reduced to manslaughter (*Sacramento Bee* 12 June 1981) and *People v Wilson* (unreported) (1985) in which, through plea-bargaining, it was agreed that Wilson plead guilty to attempted murder (Humphry and Wickett, 140).

¹⁸⁶ (Unreported) *N.Y. Times* 14 Oct. 1939.

¹⁸⁷ Kamisar, 1022 citing Judge Hand's comments in a later case involving Repouille's petition for naturalisation; *Repouille v United States* 165 F. 2d 152, 153 (1947).

¹⁸⁸ For example, *People v Greenfield* (unreported) in which the defendant had chloroformed his imbecile teenage son to death; *N.Y. Times* 12 May 1939.

¹⁸⁹ See G. Williams, 'Euthanasia and Abortion' (1966) 38 *U.Colo.L.Rev.* 178, 184-187 for a transcript of this case.

¹⁹⁰ The Attorney-General had waived the charge of murder and the defendant had been allowed to enter a plea of guilty to the crime of manslaughter.

¹⁹¹ Williams, 'Euthanasia and Abortion,' 186. For other instances where the court has dismissed charges and acquitted the defendant, see also *People v Semel* (unreported) *N. Y. Times* 15 Aug. 1985 (judge

More usually, acquittals in mercy killing cases result from a jury determination.¹⁹² A recent case which illustrates the operation of this form of leniency in mercy killing cases in the United States is *People v Harper* involving the assisted suicide of an elderly cancer patient by her husband.¹⁹³ The defendant and his ailing wife had travelled from California to the State of Michigan in the belief that assisted suicide was not unlawful in that State. The defendant assisted his wife to commit suicide by securing a bag over her head. After his wife's death he immediately contacted the police to advise them of what he had done and was subsequently charged with murder. Although the defendant had performed the act which brought about the death of the deceased, he was acquitted by the jury.¹⁹⁴

Jury Acquittals on the Grounds of Temporary Insanity

In quite a number of cases, the mercy killer has been acquitted on the grounds of temporary insanity and this has, in practice, become quite a common method of dealing with mercy killers in the United States. One such case attracting widespread publicity was the 1967 case of *People v Waskin*.¹⁹⁵ The defendant, a 20 year old college student, was charged with the murder of his mother after shooting her in the head three times. His mother who had been suffering from terminal leukemia, was experiencing great pain and had apparently begged her son to kill her. She had previously made an unsuccessful attempt to commit suicide. After only forty minutes deliberation, the jury found the defendant not guilty by reason of insanity. However, the jury found that he was no longer insane and he was accordingly released. Another much publicised case was that of *People v Zygmank* in 1973.¹⁹⁶ The deceased had become a quadriplegic as a result of a motorcycle accident. He had made the defendant, his brother, promise that he would kill him, and the defendant complied with this request by shooting his brother in the head with a sawn-off shot gun. The defendant was charged with first-degree murder but was subsequently acquitted by the jury on the grounds of temporary insanity.¹⁹⁷ As these cases illustrate, temporary insanity has frequently been relied upon as the basis for an acquittal in mercy killing cases even though there was clearly no real basis for the insanity defence.¹⁹⁸ The clear attraction of this technique for juries in cases of this kind is that an established legal category can be invoked which allows for allowing total exculpation of the defendant.

dropped murder and manslaughter charges); *People v Shick* (unreported) *Associated Press* 8 Feb. 1982 (judge acquitted defendant of murder charges arising from the shooting of his bedridden wife.)

¹⁹² See I. Horowitz, 'The Effect of Jury Nullification Instruction on Verdicts and Jury Functioning in Criminal Trials' (1985) 9 *Law & Hum.Behav.* 25, 29-30 for some discussion of jury acquittals in these circumstances.

¹⁹³ (Unreported) *N. Y. Times* 26 Aug. 1990.

¹⁹⁴ Note, 'Hemlock Member is Acquitted of Murder' (1991) 18 *World Right to Die Newsletter* 2.

¹⁹⁵ (Unreported) *Chicago Tribune* 10 Aug. 1967.

¹⁹⁶ (Unreported) 15 Oct. 1973, Super. Ct., Monmouth County, N.J.

¹⁹⁷ For a discussion of this case, see P. Mitchell, *Act of Love* (1976). For further examples of jury acquittals in mercy killing cases based on the ground of temporary insanity see Kamisar, 1019-1022.

¹⁹⁸ Glantz, 234; A. Morris, 'Voluntary Euthanasia' (1970) 45 *Wash.L.Rev.* 239, 242.

Leniency in Sentencing

Of those cases which have resulted in a conviction, (usually as a result of the defendant entering a plea of guilty), the courts have usually been extremely lenient in the imposition of sentence.¹⁹⁹ A good example, is the case of *People v Collums* in which the defendant was charged with first-degree murder for the shooting of his hospitalised brother who had been suffering from Alzheimer's disease.²⁰⁰ As a result of a lengthy process of plea-bargaining, the district attorney sought a five year prison sentence which the defence had accepted. However, the judge postponed passing the sentence for another ten years, in effect making it ten years probation. He had also ordered the defendant to do ten hours of work a week as a volunteer in a senior citizen centre.²⁰¹ Another such case is that of *People v Reinecke* in which the 84 year old defendant had been charged with murder after strangling his 74 year old wife who was suffering from terminal cancer. The defendant in this case was found guilty but was placed on probation after the State attorney said that society needed no protection from this man.²⁰²

Executive Clemency and Parole

Examination of the mercy killing cases in the United States reveals that there have also been instances of exercise of clemency, at some stage after the sentence has been imposed. One example is the early case of *People v Noxon* in which the defendant had been convicted of first-degree murder for electrocuting his mongoloid son. The death sentence was commuted to life imprisonment and later reduced to six years to life in order to make him eligible for parole. After serving four and a half years imprisonment, the defendant was released.²⁰³ A more recent example can be found in the case of *People v Gilbert*.²⁰⁴ In 1985, the defendant was convicted of the murder of his 73 year old wife who had been suffering from an incurable illness.²⁰⁵ He was sentenced to the mandatory minimum prison term of 25 years but was granted clemency on humanitarian grounds and was released after spending five years in prison.²⁰⁶

¹⁹⁹ In addition to the cases referred to in the body of the text, other examples where mercy killers have received non-custodial sentences include; *People v Healy* (unreported) in which a 71 year old lady from California had pleaded guilty to a charge of voluntary manslaughter for killing her bedridden husband so as to end his misery. She was placed on 5 years probation, fined \$10,000 and ordered to perform 1000 hours of community service work; *Associated Press Report* 19 June 1984; *People v Sallander* (unreported) in which the defendant after pleading guilty to a murder charge was sentenced to five years probation; *Houston Chronicle* 23 Jan. 1986; *People v Cooper* (unreported) in which the defendant had ended his terminally ill uncle's life with an overdose of drugs and had pleaded guilty to a charge of voluntary manslaughter. He was placed on probation for five years and was fined \$150; *Pasadena/Altadena Weekly* 16-22 Jan. 1986. Note also *People v Hoffman* (unreported) *Tampa Tribune* 22 June 1979; *People v Stephenson* (unreported) *N.Y. Times* 12 May 1984; *People v Wilson* (unreported) *San Bernardino Sun* 16 July 1985.

There have also been a number of 'mercy assisted suicides' in which lenient sentences were imposed; see, for example, *People v Taylor and King* (unreported) *Hatford Courant* 19 May 1981 (suspended prison sentence of two to four years for charges of manslaughter).

²⁰⁰ (Unreported) *Dallas Morning News* 5 March 1982.

²⁰¹ *Ibid.*

²⁰² (Unreported) (1967); see Glantz, 233; Humphry and Wickett, 92, 235.

²⁰³ (Unreported) (1943); see Humphry and Wickett, 44.

²⁰⁴ (Unreported) *N.Y. Times* 10 May 1985.

²⁰⁵ *Ibid.*

²⁰⁶ *Washington Post* 3 Aug. 1990.

United Kingdom

In the United Kingdom, mercy killing cases have, in the main, also been treated with remarkable leniency. As in the other jurisdictions under consideration, there are a number of possible outcomes for mercy killing cases in the United Kingdom criminal justice system; prosecutorial discretion exists as to whether charges should be brought²⁰⁷ or whether charges should be laid for a lesser offence;²⁰⁸ where cases proceed to trial, juries may resist conviction²⁰⁹ or find the mercy killer guilty of some lesser charge; judges, in the exercise of sentencing discretion, may choose to deal leniently with the offender;²¹⁰ and where a strict sentence is imposed,²¹¹ there is always the possibility of executive clemency.²¹² It was noted earlier that in the United States, juries have frequently acquitted mercy killers on the grounds of 'temporary insanity',²¹³ but this particular option is not open to juries in the United Kingdom.²¹⁴ However, a distinctive feature which has emerged from the mercy killing cases in the United Kingdom has been the use of the defence of diminished responsibility introduced under the *Homicide Act 1957* (U.K.).²¹⁵

²⁰⁷ One notable example where the prosecution decided not to proceed with charges of assisted suicide involved the writer and euthanasia advocate, Derek Humphry. Humphry had publicly admitted that he had assisted his wife Jean to commit suicide at her request during the final stages of her terminal cancer by supplying her with a lethal dose of drugs. In fact this was the subject of a biography about his wife's death, entitled *Jean's Way* (1978). Following this publication and the public stir which it provoked, the police interviewed Humphry. He immediately confessed his culpability to the police for assisting his wife's suicide in contravention of the *Suicide Act 1961* (Eng.) and offered to plead guilty at any trial. However, some months later he was advised by the public prosecutor that he would not be charged; see B. Wooten, 'The Right to Die' (1976) 46 *New Society* 202.

²⁰⁸ For example, *R v Houghton* (unreported) *Daily Mail* 15 May 1985 in which the defendants, the parents of the deceased, were initially indicted for murder for asphyxiating their 22 year old quadriplegic son who had begged them to assist him to die. They subsequently negotiated a plea of guilty to the reduced charge of manslaughter. They were placed on probation for two years.

²⁰⁹ For example, Williams, *The Sanctity of Life and the Criminal Law*, 293 referring to a 1927 case where a man was prosecuted for murder after having drowned his incurably ill child who was suffering from tuberculosis and gangrene of the face. He was found not guilty by the jury.

²¹⁰ For example, *R v Houghton* (unreported) *Daily Mail* 15 May 1985, noted above, n. 208; *R v King* (unreported) *The Times* 16 Oct. 1953 in which a woman who had pleaded guilty to a charge of attempted murder of her dying husband was granted a conditional discharge; *R v Thompson* (unreported) in which a brother and sister pleaded guilty to the attempted murder of their dying mother after giving her a drug overdose. The deceased, who had been suffering from cancer, had been experiencing great pain and repeatedly expressed a wish to die. She survived the overdose but died some weeks later from her cancer. The judge described the case as exceptional and granted the defendants a 12 month conditional discharge; *The Times* 14 Nov. 1990.

There have also been cases of 'mercy assisted suicide' where charges have been laid for aiding and abetting suicide resulting in conviction of the offender, but giving rise to fairly lenient sentences with the majority of those convicted being discharged or given suspended sentences of imprisonment; Wooten, 202. One such example is *R v Beecham* (unreported) *Daily Telegraph*, 18 Feb. 1988, in which the defendant had assisted his daughter to commit suicide by connecting a hose from the exhaust of her car to its interior. His daughter had been seriously afflicted with multiple sclerosis and had, on a number of previous occasions, unsuccessfully tried to commit suicide. The defendant pleaded guilty to a charge of aiding and abetting suicide and was given a twelve month suspended prison sentence. For discussion see J. Horder, 'Mercy Killings - Some Reflections on the *Beecham* Case' (1988) 52 *J.Crim. Law* 309; J.A. Laing, 'Assisting Suicide' (1990) 54 *J.Crim. Law* 106.

²¹¹ In practice, this is usually as a result of the mandatory sentence of life imprisonment for murder.

²¹² See also R. Leng, 'Mercy Killing and the C.L.R.C.' (1982) 132 *New L.J.* 76.

²¹³ See above, 141.

²¹⁴ Note also Williams, *The Sanctity of Life and the Criminal Law*, 293 where he suggests that the English jury is less prone to take the law into its own hands than its counterpart in the United States.

²¹⁵ It should be noted that although the defence of diminished responsibility is available in a number of Australian jurisdictions (A.C.T. s. 14 *Crimes (Amendment) Ordinance* (No. 2), 1990; N.S.W. s. 23A *Crimes Act 1900*; N.T. s. 37 *Criminal Code* 1983; Qld. s. 304A *Criminal Code* 1899) in practice, it has rarely been used in mercy killing cases. One possible explanation for the difference in use of the defence in the United Kingdom and Australia is that the sentence for murder in the United Kingdom is mandatory life imprisonment, whereas in two of the Australian jurisdictions in which the defence of diminished responsibility is available (the Australian Capital Territory and New South Wales) the court

Defence of Diminished Responsibility

Section 2(1) of the *Homicide Act 1957* (U.K.) provides that where a person kills while suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impairs his or her mental responsibility for his or her acts or omissions in doing or being a party to the killing, he or she shall not be guilty of murder but of manslaughter. When this defence was initially introduced under s. 2 of the *Homicide Act 1957* (U.K.), it was intended to deal with identifiable forms of mental disorder which fell outside the narrow terms of the insanity defence and to allow sentencing discretion in cases where a killing could be linked to such a disorder.²¹⁶ Notwithstanding the specific nature of the forms of mental disorder which come within the defence, it has been broadly interpreted to cover cases of mercy killing. The reality is that in genuine cases of mercy killing, the defence of diminished responsibility is not interpreted in accordance with strict psychiatric concepts but in accordance with the morality of the case.²¹⁷ Thus, the depressed state of mind of the offender at the time of the killing is often taken to amount to 'abnormality of mind' resulting in the substantial impairment of mental responsibility, within the meaning of the section.²¹⁸ The success of this defence depends upon the willingness of a doctor to testify as to the defendant's mental state and to some extent the connivance of the prosecution and judge in not challenging the medical evidence.²¹⁹ In practice, once the psychiatric experts' 'sympathies are engaged' it is not difficult to get them to testify, their evidence is let in without challenge and the jury invariably accepts the defence, even on the flimsiest grounds.²²⁰ This has been particularly significant in the United Kingdom in view of the mandatory life sentence for murder. By invoking the defence of diminished responsibility, a verdict of manslaughter can be returned and the court then has considerable discretion with regard to sentencing.

Numerous cases can be cited to illustrate the operation of the defence of diminished responsibility in the context of mercy killings cases.²²¹ For example, in the case of *R v Johnson*, in which the father of a mongoloid child had killed the child by putting a gas poker in the child's cot, the jury accepted the defence counsel's plea of diminished responsibility and found the defendant not guilty of murder but of manslaughter.²²² Similarly, in *R v Jones* a 29 year old man suffocated his mother who was in an advanced stage of terminal cancer. He had recently watched his father suffer a painful and lingering death by the same disease and was in a condition of severe anxiety, despondency and despair. A plea of

has a discretion in sentencing for murder. In these circumstances there would be less incentive to rely on the defence.

²¹⁶ The key elements of s. 2 are set out above.

²¹⁷ Williams, *Textbook of Criminal Law* (1983) 693.

²¹⁸ This is the case notwithstanding the requirement in the section that it stemmed from 'arrested development', 'inherent causes' or 'disease or injury'.

²¹⁹ Lawton, 461.

²²⁰ Williams, *Textbook of Criminal Law*, 686.

²²¹ According to Home Office research, between 1975 and 1968 there were 23 such cases; E. Gibson and S. Klein, *Murder 1957-1968*, A Home Office Statistical Division Report on Murder in England and Wales, Table 42. For documentation of some of the mercy killing cases in the United Kingdom, see N. Reed, 'Mercy Killing: Exit's Evidence to the Royal Commission on Criminal Procedure' (1982) 7 *Polytechnic L.Rev.* 17, 17-18 and Leng.

²²² (Unreported) *The Times* 2 July 1960.

guilty to manslaughter on the basis of diminished responsibility was accepted by the court.²²³ In the more recent case of *R v Fairhead* the defendant faced criminal charges for the killing of her husband who was suffering from multiple sclerosis. She had pleaded not guilty to murder but guilty to a charge of manslaughter on the grounds of diminished responsibility and this plea was accepted by the prosecution.²²⁴ These cases are simply illustrative of the now well established practice in the United Kingdom of the prosecution and the courts accepting pleas of diminished responsibility on charges of murder in genuine cases of mercy killing and this has, in fact, come to be the most common way in which mercy killing cases in the United Kingdom are dealt with.²²⁵

Leniency in the Exercise of Sentencing Discretion

In circumstances where charges against a mercy killer result in a conviction, (most usually for manslaughter, following acceptance of a plea of diminished responsibility), the judges, in the exercise of their sentencing discretion, have generally dealt leniently with such offenders, frequently imposing non-custodial sentences. Thus, for example, in the case of *R v Jones*²²⁶ (noted above²²⁷) in which the defendant was convicted of manslaughter, Watkins J. held that the appropriate sentence in the circumstances was a conditional discharge. In many of the cases the defendants have been placed on probation.²²⁸ For example, in *R v Fairhead*, (referred to above²²⁹), the defendant was placed on two years probation, after having killed her suffering husband.²³⁰ In some cases, probation is granted subject to the condition that they attend for regular psychiatric treatment.²³¹ In cases where a custodial sentence is imposed, it has often been of relatively short duration.²³²

Executive Clemency and Parole

As in the other jurisdictions under consideration, where a more substantial sentence of imprisonment is imposed in respect of a mercy killing, the severity of that sentence may be mitigated by the exercise of executive clemency. This is usefully illustrated in the early case of *R v Brownhill* in which the defendant was convicted for the murder of her 31 year old imbecile son. The defendant was soon to undergo a serious operation and had been concerned about the fate of her son if she did not survive. She was sentenced to death with a strong recommendation for mercy but was reprieved within

²²³ (Unreported) the *Guardian* 4 Dec. 1979.

²²⁴ (Unreported) the *Mercury* 21 June 1990. For further examples of English cases involving a successful plea of diminished responsibility in mercy killing cases, see *R v Taylor* (1980) C.L.Y. 510; *R v Gray* (1965) J.P.N. 819; *R v Price* (unreported) *The Times* 22 Dec. 1971.

²²⁵ Leng, 76.

²²⁶ (Unreported) the *Guardian* 4 Dec. 1979.

²²⁷ See above, 144-145.

²²⁸ For example, *R v Price* (unreported) *The Times* 22 Dec. 1971; *R v Fairhead* (unreported) the *Mercury* 21 June 1990. Note also Humphry and Wickett, 238 where the authors estimate that more than 90% of the defendants in mercy killing cases who have pleaded guilty to manslaughter on the basis of diminished responsibility have been placed on probation.

²²⁹ See above, text accompanying n. 224.

²³⁰ (Unreported) the *Mercury* 21 June 1990.

²³¹ For example, *R v Price* (unreported) *The Times* 22 Dec. 1971.

²³² For example, *R v Brown* (unreported) Dec. 1961 Edinburgh High Court; *R v Masters* (unreported) 1 July 1985, Exeter Crown Court.

two days and pardoned, and set free three months later.²³³ The possibility of a reprieve for persons convicted of murder was of particular relevance prior to the introduction of the *Homicide Act 1957* (U.K.) because before that time, murder carried a mandatory death sentence. The exercise of executive clemency continues to be of relevance in the United Kingdom in cases where a mercy killer is actually convicted of murder in view of the mandatory life sentence for murder. This is illustrated by the case of *R v Cocker*. The defendant had been convicted of murder and was given a mandatory life sentence for helping his incurably ill and grievously suffering wife to die. After serving four years of his life sentence he was released.²³⁴

PART III

Discrepancies Between the Criminal Law Principles and the Law in Practice

It is evident from the foregoing analysis of prosecutions of doctors and mercy killing cases generally that a glaring gap exists between the law in theory and the law in practice. As noted above, although questions of motive are strictly speaking irrelevant for the purposes of establishing criminal liability, in practice, they will often be decisive in determining the outcome of cases of active euthanasia and mercy killing.²³⁵ Without disputing that such cases ought to be dealt with leniently, it is submitted that there are certain fundamental problems with the present legal position which tolerates serious inconsistencies between legal principles and the law in practice. First, there is the concern that because the administration of the law depends to such a large extent on intangible considerations of sympathy, there is no guaranteed consistency of application, thus raising serious questions regarding justice and equality before the law. The second problem is that the enormous discrepancies between the law in theory and the law in practice threaten to undermine public confidence in the law and bring it into disrepute. There are a number of further problems which relate specifically to the issue of medically administered active voluntary euthanasia. One such problem is that the present ad hoc approach fails to establish any legal precedent by which medical decisions in the context of terminal patients can be made and evaluated. A related concern is that there is a very real risk that the illegality and secrecy associated with the practice of active voluntary euthanasia tends to undermine the rights of patients. Separate attention will now be given to each of these concerns.

²³³ (Unreported) *The Times* 4 Dec. 1934, *The Times* 4 March 1935. Note also the case of *R v Long* (unreported) in which the defendant had gassed his deformed and imbecile 7 year old daughter to death. He pleaded guilty and was sentenced to death, but within a week the sentence was commuted to life imprisonment; *The Times* 29 Nov. 1946.

²³⁴ Note, 'Tony Cocker' (1992) 45 *V.E.S. Newsletter* 4.

²³⁵ See above, 113-114.

No Guaranteed Consistency in the Application of the Law

As we have seen, in the majority of cases, the defendants have been treated with considerable restraint and leniency. However, the administration of the law in practice is such that there is no guaranteed uniformity of treatment, and restraint in the application of the criminal law cannot be reckoned as a certainty.²³⁶ Whilst in the majority of cases, the defendant has completely escaped criminal liability, or is convicted of some lesser offence and given a light sentence, there have also been cases in which the criminal law has been much more rigorously enforced.²³⁷ Attempts have been made to explain the different approach taken in some of these cases on the basis of their particular facts and circumstances.²³⁸ However, the point nevertheless remains that there are no objective criteria or standards to determine the outcome of mercy killing cases.²³⁹ It is a basic principle of justice that like cases should be treated alike; that in the interests of justice and equality, the law must be applied with certainty and evenhandedly against all who violate it.²⁴⁰ However, as a result of the lack of uniform and objective standards applying in such cases, there is significant potential for unequal application of the law and consequently, a very real likelihood of inconsistency of results and unfairness being done to some offenders.

Whilst these comments are made in relation to mercy killing cases generally, they also have an important bearing on the prosecution of doctors for administering active voluntary euthanasia or assisting the suicide of a patient. Although in many cases, doctors have escaped liability, the fact that the administration of the law has been lenient in some cases is no guarantee that a doctor would not be prosecuted and convicted of murder or assisted suicide. The uncertainty of the present position has been acutely highlighted by the recent conviction of Dr Cox in the United Kingdom for the attempted murder of one of his patients. This case, and the public outcry that it has provoked, has seriously brought the present law into question.

²³⁶ Williams, *The Sanctity of Life and the Criminal Law*, 293, but see Kamisar, 971 who retorts that defendants are not always entitled to 'sentimental acquittals' and that the few American cases to result in conviction demonstrate the elasticity and flexibility of the law rather than any inherent inequality.

²³⁷ In support of this proposition see, for example, Humphry and Wickett, 223-224, 232 citing a study by H. Silving, 'Euthanasia: A Study in Comparative Criminal Law' (1954) 103 *U.P.A.L.Rev.* 350; D. Maguire, *Death by Choice* (1984) 22 where it is noted that the results range from outright acquittals to conviction for murder in the first-degree. For examples of murder convictions in Australia see *R v Benn* (unreported) 2 April 1964 S.C. W.A.; *R v Cullen* (unreported) 25 March 1976, S.C. S.A.; *R v Tait* (unreported) 13 June 1972, S.C. Vic.; in the United States, see *People v Roberts* 211 Mich. 187 (1920); and in the United Kingdom, *R v Simpson* (1965) 11 Cr.App.R. 218; *R v Cocker* (unreported) (1989) 37 *V.E.S. Newsletter* 2. (In some of these cases, executive clemency and/or parole determinations mitigated the severity of the sentence. See above, 138-139.)

²³⁸ See Glantz, 234; Kamisar, 972.

²³⁹ L. Kutner, 'Due Process of Euthanasia: The Living Will, A Proposal' (1969) 44 *Ind.L.J.* 539, 542.

²⁴⁰ R. Sherlock, 'Liberalism, Public Policy and the Life Not Worth Living: Abraham Lincoln on Beneficent Euthanasia' (1981) 26 *AmJ.Juris.* 47, 50; Maguire, 20.

The Law is Brought into Disrepute

Another problem which stems from the present position is that the wide discrepancy between law and practice threatens to bring the law into disrepute. There are two distinct aspects to this argument. First, with particular regard to the medical context, notwithstanding the criminal law prohibitions with regard to active voluntary euthanasia and assisted suicide, there can be no doubt that some doctors are involved in these practices. In contrast to family mercy killing cases, where it is unlikely that a killing could pass undetected, the practice of medically administered active euthanasia or doctor-assisted suicide is much less likely to come under legal scrutiny and end up before the courts.²⁴¹ To have a situation where it is commonly known that the law is being breached by the medical profession yet breaches are usually ignored or pass unpunished, threatens to undermine public confidence in the law and to bring the law into disrepute.

Turning to the second aspect of the problem, there are also serious discrepancies between law and practice in the actual punishment of offenders. Because the present criminal law principles which treat motive as irrelevant, are widely perceived as being inappropriate, devious means are frequently used to circumvent the full rigour of the criminal law. The motive of the offender is in fact being incorporated into decision-making, but only surreptitiously through the use of certain fictions or tactics. This can result in serious distortion of legal principles and widespread connivance to defeat the application of the criminal law. The foregoing analysis has drawn attention to the use of the defences of temporary insanity and diminished responsibility in the United States and the United Kingdom respectively, in cases of mercy killing. Not surprisingly, these defences, which rest upon the emotional distress of the offender, have not been raised in the few cases in which doctors have been prosecuted. Rather, doctors have tended to plead not guilty and rely on arguments based on lack of causation or lack of the necessary intention to kill and these arguments have usually been accepted by the jury, often contrary to the weight of the evidence.²⁴²

The criticism is that the use of such fictions represents a blatant abuse of the law,²⁴³ and when occurring on a regular basis, suggests that the current criminal prohibitions do not reflect common views of reprehensibility. This, in turn, indicates the need to close the gap and bring the overt culture as expressed by the law in accord with the covert culture, as expressed in what people do.²⁴⁴

²⁴¹ See also above, 117, regarding the likelihood of the practice being performed in secret and the cause of death being readily concealed.

²⁴² See above, 124-126.

²⁴³ Humphry and Wickett, 237.

²⁴⁴ E. Gurney, 'Is there a Right to Die? A Study of the Law of Euthanasia' (1972) 3 *Cumberland-Samford L.Rev.* 235, 251. Some commentators have stressed the advantages of this gap between law and practice arguing that it preserves the legal prohibition against killing, maintains the deterrent affect of the law, but at the same time provides mechanisms in the criminal justice system to allow for flexibility in the treatment of offenders; see, for example, Kamisar; D. Meyers, *The Human Body and the Law* (1970) 151; J. Childress, 'Civil Disobedience, Conscientious Objection, and Evasive Noncompliance: A Framework for the Analysis of Illegal Actions in Health Care' (1985) 10 *J.Med. & Phil.* 63, 76.

The two arguments which follow relate specifically to the medical context with regard to the practice of active voluntary euthanasia and doctor-assisted suicide.

Lack of Legal Precedent and Medical Guidance

As a result of the serious discrepancies which exist between the legal principles and the law in practice, there is no established legal precedent with reference to which medical decisions in respect of terminal patients can be made and evaluated.²⁴⁵ In theory, the medical profession and the legal system both reject active voluntary euthanasia and doctor-assisted suicide as an acceptable medical practice, yet we know that not infrequently, these practices occur. Furthermore, because active voluntary euthanasia and assisting patient suicide are criminal, doctors will inevitably feel inhibited in discussing these practices with their colleagues in an open and honest way, and consequently will not be able to benefit from criticism or support from their professional peers with regard to their involvement in these practices. This, in turn, jeopardises the quality of medical decision-making in this area.

Patients' Rights are Undermined

One matter of particular concern is that the present situation threatens to undermine the rights and interests of patients. There are a number of possible facets to this argument. One argument is that the situation is discriminatory in that the present criminality of active voluntary euthanasia and assisted suicide inevitably deters some doctors from engaging in these practices.²⁴⁶ As a result, there is inconsistency of treatment; some patients will have the benefit of practices which are denied to others. Along similar lines, it could also be argued that the criminal law prohibitions, which are in any event frequently not adhered to, may in many cases prevent doctors from doing what they think is appropriate and in the best interests of patients. A more fundamental concern is that there is a very real risk of abuse if the law condones what is an unregulated practice. Because of the present criminality of the practice of active euthanasia, doctors may engage in the practice without necessarily consulting the patient, motivated by benevolent paternalism and in the belief that they are acting in the patient's best interests. Indeed, if we examine the few cases of medically administered euthanasia which have come before the courts, it is by no means clear that the doctors' actions in these cases were performed at the request of the patient.²⁴⁷ For doctors to take these decisions upon themselves clearly undermines patient self-determination and the patient's right not to be killed without his or her consent. There is, therefore, the possibility that the present state of the law may in effect be

²⁴⁵ J. Wilson, *Death by Decision* (1975) 165.

²⁴⁶ See Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 624 where they note that for a significant proportion of the respondents who had not acted upon a patient's request for active euthanasia, the illegality of the practice had been a factor (65%).

²⁴⁷ For example, *R v Sander* (unreported) *N.Y. Times* 10 March 1950. See above, n. 67.

sanctioning such killings without providing adequate protection to unwilling victims.²⁴⁸ If active euthanasia is in fact being practised, it is imperative that these decisions are based upon the patient's choice rather than the idiosyncratic views of individual doctors.

PART IV

Problems with the Characterisation of Certain Aspects of Medical Practice

Other discrepancies between strict legal theory and the law in practice arise in respect of the characterisation of certain aspects of medical practice. For the purposes of the present analysis, attention will focus on the practices of withdrawing life-support measures and the administration of pain-relieving drugs in the knowledge that they will cause death. It will be shown that on strict legal principles, these practices would potentially attract criminal liability for murder, but they are in fact characterised in such a way as to avoid the possibility of criminal liability.

In the preceding chapter, consideration has already been given to the question whether a doctor's compliance with a patient's refusal of treatment could in principle, amount to assisting suicide, and the accepted characterisation of this form of medical practice²⁴⁹ so that issue will not be dealt with here. Suffice it to say that this is another area where every attempt has been made to interpret the law in such a way as to avoid doctors incurring criminal liability.

Withdrawal of Life-Support

As noted earlier, doctors may, in a variety of circumstances, be involved in the removal of life-support from a patient, either at the direction of a patient who has decision-making capacity or in respect of a patient lacking such capacity.²⁵⁰ For the purposes of this discussion it will be assumed that, as a matter of causation, the relevant conduct in withdrawing life-support did, in fact, cause death to occur at the time that it did,²⁵¹ and further, that the doctor either intended to cause the patient's death or was aware that the patient would die at an earlier time than he or she would have if artificial life-support was continued.²⁵²

²⁴⁸ Kutner, 542; P. Foreman, 'The Physician's Liability for the Practice of Euthanasia' (1975) 27 *Baylor L.Rev.* 54, 61.

²⁴⁹ Chapter III, 88-106.

²⁵⁰ See above, 121. For the purposes of this discussion it is assumed that it is the doctor who is physically involved in the removal of life-support. It is acknowledged, however, that in practice, medical decisions to remove life-support will usually be made by a doctor, but are frequently carried out by the attending nurse; Johnstone, 249.

²⁵¹ See chapter I, 26-27. For the purposes of the law in South Australia s. 6 of the *Natural Death Act* 1983 provides that the non-application or withdrawal of extraordinary measures from a person suffering from a terminal illness does not constitute a cause of death. For discussion regarding the scope of this provision, see chapter I, 27.

²⁵² See chapter I, 28-30.

Although it is fairly commonplace for doctors to discontinue life-support, and this is generally accepted to be proper medical practice in appropriate circumstances,²⁵³ it is far from certain that this practice is lawful.²⁵⁴ Significantly, there is considerable uncertainty within the medical profession as to the legality of this practice. In order to determine the legality of conduct involving the withdrawal of life-support it is necessary to ascertain whether this conduct is in law an act terminating life or an omission to provide further life-sustaining therapy. This characterisation is vital, since, as outlined in an earlier chapter,²⁵⁵ the criminal law attributes a different status to 'acts' as distinct from 'omissions' which can have significant legal implications in respect of the legal consequences of such conduct.

The approach of the criminal law to 'acts' which cause death is very clear cut; they are unconditionally prohibited,²⁵⁶ regardless of the relationship between the defendant and his or her victim, or whether the victim had requested that he or she be killed. If, however, the withdrawal of life-support equipment is characterised as an 'omission,' the analysis proceeds more flexibly²⁵⁷ and depends on whether the doctor was in all the circumstances under a duty to provide medical treatment. In the absence of a legal duty to provide treatment a doctor would not be criminally liable for his or her omission.

Although the characterisation of withdrawal of life-support as either an 'act' or an 'omission' is of central importance in determining the legality of that conduct, there has been relatively little consideration of how this conduct should be characterised. Indeed, because the practice is widely known to occur, without any question of criminal liability arising, it appears to be frequently assumed that this conduct must be an 'omission' in law and therefore lawful.

On the basis of the earlier analysis of acts and omissions in chapter I,²⁵⁸ it would appear that the withdrawal of life-support constitutes an 'act' in the legal sense, since turning off the switch of a ventilator,²⁵⁹ or physically removing the tubes supplying the patient with artificial nutrition and hydration, clearly involves a 'willed bodily movement' or a 'voluntary muscular contraction'.²⁶⁰ This conclusion does, of course, have significant legal ramifications. Leaving aside for the moment policy

²⁵³ See above, n. 54.

²⁵⁴ R. Blanch Q.C., New South Wales Director of Public Prosecutions, 'Withdrawing Life Support - Murder or Mercy?', paper delivered to a meeting of the Medico-Legal Society of N.S.W., 25 March (1991).

²⁵⁵ See chapter I, 10-11, 20-21.

²⁵⁶ G. Fletcher, 'Prolonging Life' (1967) 42 *Wash.L.Rev.* 999, 1012.

²⁵⁷ *Id.* 1006.

²⁵⁸ See chapter I, 12, 20.

²⁵⁹ In practice, the withdrawal of artificial ventilation may be accompanied by the administration of drugs intended to make the patient comfortable (Schneiderman and Spragg, 1987) and this clearly involves additional acts quite apart from turning off life-support.

²⁶⁰ Since ventilators and other similar forms of artificial life-support run on electricity, once a patient is placed on such a machine, a bodily movement is required to turn the machine off, unless the machine is specially designed otherwise. However, with artificial feeding, it is possible to envisage circumstances where such feeding could be terminated without any bodily movement; for example not refilling the bottle supplying artificial nutrition and hydration. More typically, however, the withdrawal of artificial feeding would involve the removal of artificial feeding tubes from the patient. So, whilst it is conceivable that the withdrawal of artificial feeding could be done by omission, for the purposes of the present discussion, it is assumed that it is generally done in a way which does involve a bodily movement.

considerations, it would mean that the withdrawal of life-support resulting in the patient's death could potentially expose doctors to criminal liability for murder.²⁶¹

The Debate

The question of whether turning off of a life-support system should be classified as an 'act' or an 'omission' has been hotly debated by a number of legal commentators.²⁶² Whilst there is some disagreement on the matter, the consensus appears to be that withdrawal of life-support from terminal patients should be considered an omission rather than a positive act.²⁶³ This is, perhaps, a predictable result, if one considers the serious consequences which the contrary view would entail. It has already been observed that removal of life-support is a common and widely accepted medical practice. There is, therefore, a natural reluctance to come to the conclusion that doctors performing this practice may be committing murder. Consequently, there has been strong motivation to interpret the actions as something other than acts of killing²⁶⁴ and every attempt has been made to justify the view that this behaviour constitutes an 'omission,' not an 'act'.

Fletcher's Classification: 'Causing Death' Versus 'Permitting Death to Occur'

George Fletcher²⁶⁵ is one of the principal contributors to this debate. He rejects a strict legalistic approach to this issue, which would equate the conduct of a doctor in turning off life-support equipment with that of a hired gunman killing in cold blood and urges that a more sensitive interpretation of the law be adopted. Fletcher proposes that the turning off of a life-support system, such as a mechanical respirator, should be classified as an omission, not an act, and he seeks to justify this proposition on semantic grounds.²⁶⁶ Whilst acknowledging that turning a respirator off requires physical movement, he argues that this should not be the controlling factor. Instead, he proposes a test for the classification of acts and omissions based on the common usage of the terms 'causing harm' and 'permitting harm to occur'.²⁶⁷ Fletcher contends that we are equipped with 'linguistic sensitivity' for the distinction between these terms which reflects a common sense perception of reality, and that we should employ this sensitivity in classifying the conduct of a doctor in turning off life-support. If a patient is beyond recovery and on the verge of death, turning off a respirator would normally be regarded as 'permitting a patient to die' rather than 'causing death'.²⁶⁸ In these circumstances, the decision to withdraw life-support is equivalent to not employing it in the first place. On this basis, he is able to conclude that turning off a respirator should be classified as an

²⁶¹ In circumstances where the patient has decision-making capacity and has requested that life-support be removed, the patient's conduct could possibly be characterised as suicidal. (For further discussion, see chapter III, 91-99.) This in turn raises the possibility of the doctor's liability for assisting the suicide of the patient. It will be argued, however, that where the doctor turns off life-support this is an act directly connected with the patient's death and the appropriate charge would therefore be for murder (assuming the necessary *mens rea* can be established) rather than assisted suicide.

²⁶² Fletcher, 1005-1014; Williams, 'Euthanasia', 20-21; *Textbook of Criminal Law* 279-283; Kennedy; H. Beynon, 'Doctors as Murderers' (1982) *Crim.L.Rev.* 17, 19-23; Gurney, 251-256.

²⁶³ For commentators in support of this view, see, for example, Fletcher and Williams.

²⁶⁴ President's Commission Report, 71.

²⁶⁵ 'Prolonging Life'. Note also G. Fletcher, *Rethinking Criminal Law* (1978) 602-610.

²⁶⁶ Beynon, 19.

²⁶⁷ 'Prolonging Life', 1007.

²⁶⁸ *Ibid.*

omission, notwithstanding that it involves some bodily movement.²⁶⁹ And whilst he concedes that some omissions may cause harm,²⁷⁰ he argues that in the context of withdrawal of life-sustaining therapy, the law must focus on the doctor/patient relationship to define legal consequences, allowing customary standards to be the controlling factor.

Clearly, however, Fletcher's proposed method of classification, based on the common usage of the terms 'causing harm' and 'permitting harm to occur,' depends, to a large extent, on the condition of the patient. He acknowledges as much by his reference to 'a patient beyond recovery and on the verge of death' and his comments to the effect that one would baulk at saying that turning off a respirator in these circumstances is causing death.²⁷¹ It logically follows that in some circumstances, turning off a respirator, or other form of life-support, does amount to 'causing death' rather than 'permitting death to occur' and would accordingly be classified as an 'act,' not an 'omission'. For example, if someone turned off a respirator which had maintained a fully conscious and reasonably healthy poliomyelitis patient for several years and which could have continued to do so for years to come, one could quite naturally describe such conduct as 'causing death'.²⁷² It may, therefore, be wondered whether such a variable test could operate satisfactorily in practice, particularly where the final determination appears to involve a qualitative judgment as to the condition and prognosis of the patient. In the interests of certainty and consistency in the application of legal principles, it could be argued that the conduct of turning off of life-support must be uniformly classified as *either* an act or an omission, and should not be determined by reference to external considerations.

Williams' Reference to 'the Substance of the Matter'

Glanville Williams²⁷³ is also of the view that turning off a respirator is an omission but he justifies this conclusion on different grounds. The essence of Williams' argument is that the moral and legal rule which distinguishes between acts and omissions must be interpreted in accordance with 'the substance of the matter'.²⁷⁴ He accepts that giving up trying to keep a patient alive may involve positive action, in the sense of willed movement, for example, disconnecting a respirator that is keeping the patient alive. He argues, however, that this need not be regarded as an 'act' for the

²⁶⁹ *Id.* 1012-1014. For other commentators in support of this reasoning see also G.P. Smith, 'All's Well that Ends Well: Toward a Policy of Assisted Suicide or Merely Enlightened Self-Determination?' (1989) 22 *U.C.Davis L.Rev.* 275, 350-351; D. Meyers, 'The Legal Aspects of Medical Euthanasia' (1973) 23 *Bio. Science* 467, 469. For criticism of Fletcher's reasoning see P. Skegg, 'The Termination of Life-Support Measures and the Law of Murder' (1978) 41 *Mod.L.Rev.* 423, 430-432 where he argues that it does not accommodate those circumstances where the conduct in question could naturally be described in terms of *either* permitting or causing death. Skegg asserts that whilst it is perfectly natural to speak of the withdrawal of artificial respiration from a patient who is beyond recovery and on the verge of death as 'permitting death', many people would probably consider it no less natural to speak of such conduct as 'causing death to occur at the time when it did'. Note also Beynon, 20 where she draws attention to what she claims is an internal inconsistency in Fletcher's analysis; if switching off is really an omission, since the doctor does not *cause* but only *permits* the death, there is surely no need for his further analysis regarding the duty concept in respect of omissions; causation is a *sine qua non* of liability.

²⁷⁰ 'Prolonging Life,' 1013-1014.

²⁷¹ *Id.* 1007.

²⁷² Skegg, 430. Moreover, according to Skegg, there are some situations which are capable of being classified as *either* causing death or permitting death to occur; see above, n. 269.

²⁷³ *Textbook of Criminal Law*, 282-283; 'Euthanasia', 20-21.

²⁷⁴ 'Euthanasia,' 20-21.

purposes of the moral and legal rule, because *in substance* it merely puts into effect a decision to take no further steps.²⁷⁵ To justify his view that stopping a respirator is not, in substance, an act of killing, Williams examines the manner in which such machines operate. He argues that if a respirator only worked as long as the doctor turned a handle and the doctor stopped turning, he would be regarded as merely omitting to save the patient's life. Alternatively, if the respirator worked electrically but was made to shut itself off every 24 hours, a deliberate failure to restart would be an omission. From this premise, he argues that it can make no moral difference that respirators are made to run continuously and therefore need to be stopped. Thus, he concludes, turning the respirator off is not a positive act of killing the patient but rather a decision to let nature take its course.

On the basis of the test put forward by Williams, the classification of conduct as an act or an omission would be made by the court on a case by case basis, according to 'the substance of the matter'. There are in fact, distinct similarities between this approach and the test proposed by Fletcher which requires consideration of whether the conduct in question can be said to have 'caused death' or merely 'permitted death to occur'. Both would ultimately require a determination by the court, based on the particular facts of the case, and the court's inquiry would inevitably turn on the question of whether it was in the circumstances appropriate to withdraw treatment.²⁷⁶

However, Williams' approach is open to the same objection as Fletcher's arguments, namely that identical conduct (i.e. physically turning off or withdrawing life-support), could be classified either as an act or an omission, depending on the surrounding circumstances. On Williams' analysis, if life-support is turned off at the request of the patient or pursuant to a *bona fide* medical decision to cease further treatment, a court would be likely to find that any physical acts involved should be disregarded, because in substance, the medical staff were merely putting into effect a decision to take no further steps. Where, however, a machine is turned off for other than *bona fide* medical reasons, for example, in order to avoid a night shift attendance on the patient, the conduct could be regarded as, in substance, an act of killing.

In view of the general criminal law principles which continue to uphold the acts/omissions dichotomy, there is, understandably strong motivation for preferring to classify 'turning off' as an omission rather than an act so as to avoid the spectre of doctors incurring criminal liability. Notwithstanding the commendable motives of legal commentators and jurists in their attempts to justify this position, there remains a fundamental difficulty with this approach. Skegg²⁷⁷ has raised the objection that this classification only works satisfactorily in circumstances where there is an appropriate duty relationship between the patient and the person who switches off the machine and in the absence of such a relationship, serious difficulties arise. Taking this reasoning to its logical conclusion, it would allow strangers to interfere and kill the patient by turning off life-support

²⁷⁵ *Ibid.*

²⁷⁶ This determination will depend on the condition and prognosis of the patient and, as Williams acknowledges (*Textbook of Criminal Law*, 283), this approach leaves it very much up to the individual doctor to determine whether life has any value for the patient.

²⁷⁷ Skegg, 432.

equipment; if the removal of life-support is held to be an omission, the stranger would commit no crime since he or she was under no legally recognised duty to act. A possible answer to this objection, raised by both Williams and Skegg, is that the withdrawal of life-support should only be classified as an omission in circumstances where there is a legally recognised duty relationship between the parties. So, if an intruder who owes no duty to the patient switches off a life-support system, his conduct will be treated as an act of murder.²⁷⁸ But, as Skegg acknowledges, this explanation is open to the objection that it is undesirable that the same physical movements should be classified either as an act or an omission, depending on who it was that switched off the machine.²⁷⁹ In the interests of certainty and uniformity in the application of the law, it is important that the classification of acts and omissions be determined without reference to what are arguably peripheral considerations.

Kennedy's Analysis

Not all commentators support these attempts to justify the practice of turning off life-support systems by classifying turning off as an omission. Kennedy, for example, rejects this approach as 'elaborate and unsatisfactory'.²⁸⁰ In his view, to describe the turning off of life-support as an omission does some considerable violence to ordinary English usage and represents an attempt to solve the problem by logic-chopping.²⁸¹ Kennedy argues that in circumstances where a patient is dependent on life-support, and the doctor knows that the patient will die if the life-support measures are removed, in determining the liability of the doctor in withdrawing life-support, a distinction must be drawn between: (i) the situation where the patient requests that further support be terminated; and (ii) where life-support is turned off without the consent of the patient. In the former case, a doctor's compliance with the patient's request would not attract criminal liability; not because it is an omission to treat rather than an act of killing, but on a number of other interrelated grounds. First, he argues, there is the libertarian premise that a person's position should not be irremediably worsened by another's conduct.²⁸² Turning off life-support permits other factors to intercede and thrusts the decision back on the patient. Second, because of what he refers to as the 'red light' rule; that it is better to have a clear, albeit crude, general rule condemning all acts of killing and inviting leniency in cases of justifiable transgression. Third, from an evidentiary point of view, he argues that there is a significant distinction between the termination of life-support and other forms of active killing such as stabbing which are potentially more open to abuse. Finally, he suggests that since a patient requesting termination of life-support is a relatively rare phenomenon, the criminal law can respond to it as a tolerable and justifiable exception to basic criminal law rules. In the second situation, however, where life-support is intentionally terminated without the knowledge and the consent of the dependent patient, the conduct clearly amounts to murder regardless of the actor's motive.

²⁷⁸ Williams, 282 where he takes this reasoning further, arguing that the intruder has no responsibility for or authority in respect of the patient - he or she does not take part in the decision whether to continue medical treatment or not, so what he or she does is a positive act of intervention. An alternative analysis is that where an unauthorised person interferes with the treatment of a patient they pull onto themselves a duty of care such that they could be liable for an omission to act.

²⁷⁹ Skegg, 432.

²⁸⁰ 'Switching Off Life-Support Machines: The Legal Implications,' 444.

²⁸¹ *Id.* 445.

²⁸² Kennedy, 449; Beynon, 23.

In effect, Kennedy avoids characterising the relevant conduct of withdrawing life-support as either an 'act' or an 'omission'. He is, however, at pains to point out that the conduct we are considering involves *discontinuation* of treatment, and that there is an important distinction between a request by a patient that treatment be discontinued which is complied with on the one hand, and a request by a patient that someone stabs him or her to death which is complied with on the other. Whilst the former does not, on his analysis attract liability, the latter does.²⁸³

The truth of the matter is that the acts/omissions dichotomy presents a real dilemma in cases where the discontinuation of treatment involves a willed bodily movement. Clearly, steps taken to turn off artificial ventilation or remove artificial feeding tubes are performed pursuant to a decision to omit further treatment in respect of a patient (either at the patient's direction, or where a decision is made in respect of a patient who lacks decision-making capacity) and it is beyond doubt, that in some circumstances, this course of action will be appropriate.²⁸⁴ This does not, however, alter the fact that technically speaking, these various forms of withdrawal of medical care involve 'acts' in the sense of 'willed bodily movements' or 'muscular contractions.' The position is, perhaps, clearest in relation to the issue of removal of life-support equipment; as one commentator has argued, once life-support equipment has begun to operate on a patient, it is fallacious to argue that a cessation of such treatment is a mere omission and not an act in the legal sense.²⁸⁵ The doctor must physically turn the switch to the off position and this entails positive action.²⁸⁶

The Approach of the Courts: Characterisation in Practice

It is, in all the circumstances, not surprising that the courts, when faced with difficult questions of characterising medical conduct, have generally glossed over the issue or have simply assumed that withdrawal of treatment constitutes an omission, notwithstanding that it may involve some positive action.

Since the issue of withdrawal of life-support has been most frequently litigated in the United States, most of the relevant cases come from that jurisdiction. In a number of American cases the courts have upheld the right of a patient to refuse treatment, even in circumstances where that involves having ventilators or artificial feeding tubes disconnected.²⁸⁷ However, these cases have generally been non-

²⁸³ 'Switching Off Life-Support Machines: The Legal Implications,' 449. Although not specifically stated by Kennedy, a convincing way of distinguishing between discontinuance of treatment and other forms of active assistance such as stabbing or the administration of a lethal injection performed at the request of the patient, is by relying on the patient's right to refuse treatment and the fact that a doctor may lawfully act on the patient's request - indeed is obliged to do so, if he or she is to avoid liability for battery. This argument is developed further, see below, 161-163.

²⁸⁴ See above, n. 54 for references in support of the ethical permissibility of terminating life-support.

²⁸⁵ W. Cannon, 'The Right to Die' (1970) 7 *Hous.L.Rev.* 654, 659.

²⁸⁶ *Ibid.* For other commentators who are of the view that turning off life-support is an act, not an omission, see, for example, G. Sharpe, *The Law and Medicine in Canada* (2nd ed., 1987) 303; D. Lanham, 'The Right to Choose to Die with Dignity' (1990) 14 *Crim.Law.J.* 401, 428; J. Riordan (ed.) *The Laws of Australia*, Criminal Law, Homicide, 66-67.

²⁸⁷ For example *Satz v Perlmutter* 362 So. 2d 160 (1978); *Severns v Wilmington Medical Center* 421 A. 2d 1334 (1980); *In re Colyer* 99 Wash. 2d 114 (1983); *Bartling v Superior Court* 163 Cal. App. 3d 186 (1984); *Brophy v New England Sinai Hospital, Inc.* 497 N.E. 2d 626 (1986).

criminal in nature, so the question of classification of withdrawal of life-support has only been indirectly addressed, if at all.²⁸⁸

A notable exception was the case of *Barber v Superior Court*²⁸⁹ involving a criminal prosecution of two doctors for murder and conspiracy to commit murder for their conduct in removing life-support equipment and intravenous tubes supplying nutrition and hydration to a dying patient. Quite clearly, therefore, determination of whether the doctors' conduct in removing the life-support equipment and feeding tubes was an 'act' or an 'omission' was central to the doctors' criminal liability. Although the conduct in question involved positive action in the sense of 'willed bodily movements,' the court nevertheless held that the cessation of these life-support measures was not an affirmative act but rather a withdrawal or omission of further treatment.²⁹⁰ The approach taken by the court seems to be akin to that suggested by Williams' that account must be taken of 'the substance of the matter'. The court was of the view that:

Even though these support devices are, to a degree, 'self propelled', each pulsation of the respirator or each drop of fluid introduced in the patient's body by intravenous feeding devices is comparable to a manually administered injection or item of medication. Hence 'disconnecting' of the mechanical devices is comparable to withholding the manually administered injection or medication.²⁹¹

Thus, the court held that for the purpose of assessing a doctor's liability, withdrawal of life-support equipment or intravenous tubes should be regarded as equivalent to initially withholding the procedures.²⁹² Since the conduct could be characterised as an omission, the legality of the conduct turned on the question of the scope of the doctors' duty and the doctors were held not to be liable.

The question of characterisation of withdrawal of life-support, and more particularly, the legality of this practice, has not directly arisen for judicial consideration in Australia or the United Kingdom.²⁹³

²⁸⁸ One explanation for the failure of the courts in the United States to address this issue is the emphasis which has been given in many cases to the patient's constitutional right to refuse treatment which has led to an assumption by the courts that doctors would not incur criminal or civil liability for taking steps in facilitating the exercise of that right.

²⁸⁹ *Barber v Superior Court* 195 Cal. Rptr. 484 (1983).

²⁹⁰ *Id.* 490.

²⁹¹ *Ibid.*

²⁹² N. Cantor, *Legal Frontiers of Death and Dying* (1987) 32.

²⁹³ There has been a recent New Zealand case in which the High Court gave doctors an immunity from murder or manslaughter charges in a case involving the withdrawal of life-support from a irreversibly brain damaged patient. Because of concern about criminal liability, the doctors had applied to the court, seeking a declaration that the withdrawal of artificial ventilatory support would not be unlawful. For discussion of this case, see chapter I, n. 92.

For the purposes of Australian law, should be noted that in *R v Crabbe* (1985) 58 A.L.R. 417, 421 (a case dealing with the mental element for murder at common law; see chapter I, 28-29), the High Court expressed the view that not every fatal act done with the knowledge that death or grievous bodily harm will probably result is murder, since the act may be lawful, that is, justified or excused by law. This possible exception will be discussed below, 171-172 in the context of the legality of administering pain-relieving drugs, where it may have greater relevance.

Whilst the issue of characterisation of withdrawal of life-support has not directly arisen before the courts in Australia, there have been publicised instances in which artificial life-support has been switched off at the request of the patient; for example, the case which occurred at St. Vincent's Hospital in March 1988, in which the doctors, at the request of a patient suffering from fatal motor neurone disease, turned off the artificial ventilator which had been keeping the woman alive. See above, n. 51.

There have, however, been a number of cases in which the courts have accepted that doctors have acted properly in withdrawing artificial life-support from brain-damaged patients.²⁹⁴ Thus, in prosecutions of persons whose conduct had led the victim to be dependent on life-support, the courts have held that the conduct of the doctor in disconnecting life-support did not break the chain of causation between the initial injuries and the death. These cases tend to support the view that the withdrawal of life-support is characterised by the courts as an omission to provide further treatment, rather than an act which causes death.²⁹⁵

Thus, in cases involving the withdrawal of treatment, for example, disconnecting life-support equipment²⁹⁶ or the removal of artificial feeding tubes,²⁹⁷ the courts have usually proceeded on the basis that these are essentially cases of omission notwithstanding that they may entail some positive action. This conclusion is, however, difficult to justify on strict legal principles. The removal of life-support clearly does involve an 'act' in the strict legal sense, and, provided the other necessary requirements are fulfilled, it would *prima facie* constitute murder if the patient's death results.

Policy Considerations

There are undoubtedly significant policy considerations behind the approach of the courts and the views of many commentators in finding that the withdrawal of life-support is in law an omission, not an act. As noted earlier,²⁹⁸ the withdrawal of life-support is now fairly well established medical practice, and there is naturally a reluctance to interpret that practice in such a way as to raise the spectre of doctors incurring criminal liability. Indeed, it would seem that every possible effort has been made to interpret the conduct of the doctors in such a way as to sanction their practices and avoid a finding of criminal liability.

'Killing' and 'Letting Die'

Quite apart from the issue of criminal liability, the acts/omissions distinction has been influential in shaping attitudes in relation to the taking of human life. Commentators have seized on this distinction in order to distinguish between the humane termination of medical care on the one hand and unlawful killing on the other and this reasoning is also reflected in the official statements of some medical organisations with regard to the withholding of treatment and the practice of active euthanasia.²⁹⁹ Distinctions have been drawn between 'causing death' and 'allowing death to occur' or

²⁹⁴ P. Skegg, *Law Ethics and Medicine* (Revised ed., 1988) 166; *Finlayson v H.M. Advocate* [1978] S.L.T. (Notes) 60; *R v Malcherek* [1981] 1 W.L.R. 690; *R v Steel* [1981] 1 W.L.R. 690; *R v Kinash* [1982] Qd.R. 648.

²⁹⁵ See also F. Galbally, 'Death by Statute' (1981) 55 A.L.J. 339, 343 and the discussion in chapter I, 27.

²⁹⁶ For example, *Satz v Perlmutter* 362 So. 2d 160 (1978).

²⁹⁷ For example, *Barber v Superior Court* 195 Cal. Rptr. 484 (1983).

²⁹⁸ See above, n. 54.

²⁹⁹ See, for example, the Statement of the Council of Judicial and Ethical Affairs of the American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment* March (1986) which states that 'for humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient to die when death is imminent. However, the physician should not intentionally cause death.' For critical analysis of the distinctions relied upon in this statement, see R. Devettere, 'The Imprecise Language of Euthanasia and Causing Death' (1990) 1 *J.Clin. Ethics* 268.

between 'killing' and 'letting die'. However, euphemisms such as 'letting die' or 'allowing death to occur' are inherently misleading and tend to obscure the real issues. The difficulty is that terms such as 'killing' or 'allowing to die' are often used not only in a descriptive sense, but are also intended to convey normative connotations. For example, 'allowing to die' is often used to communicate approval of the fact that death will occur as distinct from 'killing' which has connotations of illegitimate taking of life.³⁰⁰ Further, these terms tend to imply a number of invalid assumptions. For instance, these distinctions give rise to the assumption that acts of killing cause death, whereas, omissions to provide treatment, or 'letting die' do not.³⁰¹ However, this assumption is clearly unfounded since an omission to provide treatment can in some circumstances be properly regarded as a cause of death. These terms are also objectionable on the grounds that they appear to suggest that only acts of killing are proscribed as unlawful and that omissions to act or passive euthanasia are legally permissible. This suggestion is also quite unwarranted since the doctor's duty to his or her patient may also give rise to liability for omissions to act.

Although these distinctions between 'killing and letting die' or 'causing death and allowing death' to occur are, to a large extent, based on invalid and unfounded assumptions,³⁰² they have nevertheless gained considerable currency. In practice, the usage of these terms would tend to encourage the characterisation of the withdrawal of life-support as an omission; (i.e. a 'letting die' or 'allowing death to occur' as distinct from 'causing death' or 'killing') in order to convey the broad acceptability of this practice.

Distinction between Withholding and Withdrawing Medical Treatment

There are also other implications flowing from a strict adherence to the acts/omissions distinction. If the withdrawal of life-support is held to be an act, this would result in a distinction being drawn between initially withholding treatment, which on any analysis, is clearly an omission, and withdrawing treatment once instituted, which would be classified as an act and which would, therefore, attract different legal consequences. However, this is thought to be a most unsatisfactory distinction to draw in practice.³⁰³ As a preliminary objection, although the nature of the distinction may at first sight seem clear enough, cases that obscure it abound.³⁰⁴ But, apart from the difficulties in the application of such a distinction, its adoption is likely to have serious implications. As pointed out by the President's Commission in its Report, *Deciding To Forgo Life-Sustaining Treatment*, if the view is taken that treatment, once started cannot be stopped, or that stopping requires much greater justification than not starting, this may result in treatment being continued for longer than is optimal

³⁰⁰ President's Commission Report, 64.

³⁰¹ *Id.* 68-70.

³⁰² *Id.* 71.

³⁰³ *Id.* 73-77. See also the Hastings Center Report, 130-131; R. Weir, *Abating Treatment with Critically Ill Patients* (1989) 401-403; Cantor, 32.

³⁰⁴ See President's Commission Report, 74 for some examples which tend to obscure the distinction; disconnecting a respirator would count as stopping - but if the patient is on a respirator and the power fails, does failure to use a manual bellows system count as stopping or not starting? And what of medical therapies which require repeated applications of an intervention? Does failure to continue to reapply the intervention count as stopping or as not starting?

for the patient, even to the point where it is causing positive harm with little or no compensating benefit.³⁰⁵

According to the President's Commission, an even more troubling wrong occurs when treatment that might save life or improve health is not started because the health care personnel are afraid that they will find it legally difficult to stop the treatment if it proves to be of little benefit and greatly burdens the patient.³⁰⁶ Thus, the commission was concerned that the erection of a higher requirement for cessation might unjustifiably discourage vigorous initial attempts to treat seriously ill patients that sometimes succeed.³⁰⁷ The commission was of the view that the distinction between withholding and withdrawing treatment is not of itself of moral significance; if there is justification for not commencing a treatment, the same grounds should also be sufficient for ceasing it.³⁰⁸ The commission concluded, neither law nor public policy should mark a difference in moral seriousness between stopping and not starting treatment.³⁰⁹

There are clearly valid reasons why there should be no distinction between withholding medical procedures and terminating such procedures once instituted. In some of the American cases the courts have recognised these problems and have specifically stated that no such distinction will be made.³¹⁰ As we have seen, one way of achieving this result (but not necessarily the *only* way), is to hold that withdrawal of life-support amounts to an omission, in the same way that withholding treatment is in law an omission.³¹¹

A Critique of the Present Legal Analysis

Although there are clearly significant policy considerations involved, it is submitted that there are some fundamental problems inherent in the present legal analysis. To hold that the withdrawal of life-support constitutes an omission is simply a policy decision which ignores the reality that this conduct involves 'willed bodily movements' or 'voluntary muscular contractions'. Problems arise because the prevailing interpretation involves legal fictions and the distortion of accepted legal principles. This is particularly serious having regard to the importance of the acts/omissions distinction in determining criminal liability. There are undoubtedly difficulties with the acts/omissions distinction. Not only is the distinction between acts and omissions often very difficult to draw in practice, in many cases it fails to provide an adequate foundation for the moral and legal

³⁰⁵ President's Commission Report, 75.

³⁰⁶ *Ibid.*

³⁰⁷ *Id.* 61-2, 75-6. Indeed, as argued by the President's Commission, if there is any basis to draw a moral distinction between withholding and withdrawing treatment, it should work the opposite way; greater justification ought to be required to withhold than to withdraw treatment. This is because the effects of treatment will often be highly uncertain before the treatment has been tried. However, once the treatment has been implemented and it is clear that it is not helpful to the patient, there is then actual evidence, rather than mere surmise, to support discontinuing the treatment.

³⁰⁸ President's Commission Report, 61. See also the Hastings Center Report, 130-131.

³⁰⁹ President's Commission Report, 77.

³¹⁰ For example, *Barber v Superior Court* 195 Cal. Rptr. 484, 490 (1983); *In re Conroy* 486 A. 2d 1209, 1234 (1985).

³¹¹ See, for example, the approach taken in *Barber v Superior Court* 195 Cal. Rptr. 484 (1983).

evaluation of events leading to death.³¹² One cannot ignore the fact that strict adherence to the acts/omissions dichotomy leads to some very fine distinctions, which arguably are morally and ethically unsustainable.³¹³ For example, is it valid to hold that the ending of a program of dialysis is a mere 'omission', whilst switching off a ventilator is an 'act,' even though they are both directed at the same end, namely discontinuing life-support? The overwhelming consensus amongst commentators appears to be that in substance, there is no difference between these forms of medical practice³¹⁴ and that it is most inappropriate for liability for homicide to depend on artificial distinctions of this kind.³¹⁵ As we have seen, the response of most commentators has been to argue that although we are here dealing with conduct which can technically be described as acts, it should, nevertheless, be classified as an omission.³¹⁶ The difficulties that have been encountered in this area have led other commentators to completely reject the current conceptual framework of acts and omissions.³¹⁷ However, if we accept the need to operate within the existing legal and ethical framework, the conclusion seems inescapable that the withdrawal of life-support must be classified as an act not an omission.

If the withdrawal of life-support is characterised as an act, the obvious conclusion would appear to be that the commission of that act will constitute murder if it is accompanied by the necessary *mens rea*. Furthermore, having regard to the rules negating consent to acts which cause death, it would appear to be irrelevant that the patient had directed that treatment be withdrawn. Notwithstanding the seeming inevitability of these conclusions, it is submitted that there is an alternative method of analysis which retains the traditional acts/omissions distinction, but nevertheless, acknowledges that, in some instances, doctors may lawfully perform acts which cause death.

A Possible Solution

If we are to adhere to the acts/omissions dichotomy, the most acceptable means of overcoming present difficulties is to recognise that, in appropriate circumstances, withdrawal of treatment will be justifiable and will not result in criminal liability, even though it involves an act in the sense of a 'willed bodily movement' or 'voluntary muscular contraction' which may have been accompanied by the necessary *mens rea* for murder. This proposition is based upon the patient's fundamental right of self-determination. As previously observed, at common law, a patient who has decision-making capacity has a right to refuse treatment.³¹⁸ If this right is taken to its logical conclusion, it should enable the patient to refuse further treatment even though the implementation of that refusal may require the medical staff to take positive action (for example, the act of turning off life-support equipment or the removal of artificial feeding tubes) which is directly connected to the patient's death. This was certainly the view of the President's Commission, which stated in unequivocal terms:

³¹² President's Commission Report, 64.

³¹³ Beynon, 20; Williams, 'Euthanasia and Abortion', 183.

³¹⁴ Williams, 'Euthanasia and Abortion', 183.

³¹⁵ J.C. Smith and B. Hogan, *Criminal Law* (5th ed., 1983) 44.

³¹⁶ See the reasoning of Fletcher and Williams above, 152-155.

³¹⁷ For example, Devettere, 273.

³¹⁸ See chapter II, 33-37.

For competent patients, the principle of self-determination is understood to include a right to refuse life-sustaining treatment, and to place a duty on providers and others to respect that right. Providers, in turn are protected from liability when they act to aid a patient in carrying out that right. Active steps to terminate life-sustaining interventions may be permitted, indeed required, by the patient's authority to forgo therapy even when such steps lead to death.³¹⁹

This statement has subsequently been endorsed by the courts in the United States.³²⁰ Not only does a patient have the right to refuse treatment, the corollary of this right is that non-consensual treatment amounts to a battery. On the assumption that life-support such as artificial ventilation or artificial feeding is seen as medical treatment,³²¹ the patient's withdrawal of consent would render the continuation of that treatment a non-consensual touching and therefore a battery.³²² Thus, a doctor would have legal justification for removing life-support at the direction of the patient, notwithstanding that such removal may entail conduct of a positive nature. The doctor would simply be removing the source of a battery, which in law he or she is required to do, and thereby would be respecting the patient's right to refuse treatment.³²³ Whilst this reasoning has rarely been spelt out it is entirely consistent with recent case law from the United States³²⁴ and contemporary developments regarding the patient's right of self-determination.³²⁵

If we take the step of recognising that the withdrawal of life-support is indeed an act rather than an omission, we then have to determine what effect this conclusion has on criminal law principles generally regarding acts which cause death. In particular, consideration has to be given to whether this necessarily leads to the conclusion that patients can authorise other acts which cause death, such as the administration of a lethal injection. Indeed, concern about this very possibility underlies the reluctance of many commentators to accept that the withdrawal of life-support is an act, fearing that this would result in an erosion of the general legal prohibition of active killing.

Proponents of active voluntary euthanasia may wish to argue that it logically follows from the acceptance of the withdrawal of life-support as an act that a patient who has decision-making capacity can authorise *any* acts which cause death. Realistically, however, any change to the legality of the practice of active voluntary euthanasia is unlikely to be achieved in this way. Whilst a number of

³¹⁹ President's Commission Report, 72.

³²⁰ *In re Conroy* 486 A. 2d 1209, 1234 (1985).

³²¹ This is now the accepted view; see, for example, chapter II, 61.

³²² Some support for this view can be derived from the English case of *Fagan v Metropolitan Police Commissioner* [1969] 1 Q.B. 439.

³²³ Skegg, *Law, Ethics and Medicine* 180. See chapter II, n. 280 for consideration of the possible reliance by doctors on the defence of necessity in order to avoid criminal liability.

³²⁴ For example, *In re Farrel* 529 A. 2d 404 (1987).

³²⁵ Respect for the patient's right to refuse treatment may also be reflected in arguments based on lack of the necessary *mens rea* to convict for murder. It could, for example, be argued that a doctor who has acted upon the request of a competent patient that artificial life-support measures be removed should not be criminally liable even though he or she knew that death would probably result since the doctor's intention was to uphold the patient's right to refuse treatment rather than bring about the death of the patient. Acceptance of this argument would, however, involve legal recognition of the principle of 'double effect' which has to date not been accepted into the criminal law; for further discussion see below, 167-168.

commentators have either accepted that the withdrawal of life-support is in fact an act, or have rejected outright the acts/omission doctrine as determinative of liability, they have at the same time argued for the retention of the general legal prohibition on active killing. This, they claim, can be achieved by drawing a distinction between an act of discontinuance of medical treatment and other acts of commission, such as giving a lethal injection.³²⁶ It is suggested here that one recognises the withdrawal of artificial life-support as an act which doctors may lawfully perform at the request of the patient in the context of the patient's direction that further treatment be discontinued but, at the same time, acknowledging that this does not, of itself, lead to the conclusion that a doctor may perform other acts causing death at the request of the patient. This would have the advantage of intellectual honesty and consistent legal reasoning, avoiding the distortions and legal fictions which the present position entails.

Although this thesis is concerned with competent patients who have decision-making capacity, the implications of the foregoing reasoning for the withdrawal of artificial life-support from incompetent patients must be acknowledged. If, as has been argued, the withdrawal of artificial life-support such as turning off a ventilator or the removal of artificial feeding equipment is characterised as an act not an omission, doctors who perform such acts other than at the direction of a patient who has decision-making capacity would potentially face criminal liability for murder. This would mean that the switching off of artificial life-support in respect of an incompetent patient would be unlawful, even in circumstances where the continuation of medical treatment is believed to be medically futile. The only exception would be in those jurisdictions in which patients have a statutory right to refuse treatment which endures beyond the patient's loss of decision-making capacity.³²⁷ Whilst this is, admittedly, an unsatisfactory conclusion to draw, it is inescapable if one accepts that the withdrawal of life-support is an act not an omission. The solution to this difficulty would lie with the legislature.³²⁸

Administration of Pain-Relieving Drugs

In the context of the care of terminal patients, cases may arise in which the drugs required to alleviate pain may have the effect of shortening the patient's life. Pain-relieving drugs may be administered in a wide range of circumstances: they may be administered at the request of or with the consent of a patient who has decision-making capacity, or the doctor may determine on behalf of the patient that

³²⁶ Cantor, 34; Kennedy, 449; President's Commission Report, 72-73.

³²⁷ The only Australian jurisdictions to have introduced legislation in this area are South Australia, (*Natural Death Act* 1983); Victoria (*Medical Treatment Act* 1988, *Medical Treatment (Enduring Power of Attorney) Act* 1990 and the *Medical Treatment (Agents) Act* 1992); and the Northern Territory (*Natural Death Act* 1988). An important feature of this legislation is to provide legal protection to doctors who act upon the patient's prior direction (or in Victoria, at the direction of the holder of the power of attorney) that treatment be discontinued. See chapter VII, 296-297, 307, 310-311 respectively.

³²⁸ It should be noted that different considerations may be applicable in the United States in light of the courts' attempt to equate the rights of competent and incompetent patients with regard to the right to refuse of treatment, particularly since the United States Supreme Court in *Cruzan v Director, Missouri Department of Health* 110 S. Ct. 2841, 111 L. Ed. 2d 224 (1990) has recognised this right to have a constitutional basis. The *Cruzan* decision does, however, make it clear that States are entitled to insist upon a high standard of proof in establishing the prior wishes of a previously competent patient. See chapter II, 59-60.

such a course is appropriate, for example, in circumstances where the patient lacks the capacity to decide.³²⁹ Although it appears to be widely accepted amongst the medical profession that the administration of life-shortening palliative care is in some circumstances ethical and constitutes legitimate medical practice,³³⁰ it is open to question whether this practice is in fact lawful.

Under existing criminal law principles for murder outlined in chapter I,³³¹ liability will be established for acts which cause death if they are performed with an intention to cause death or in the knowledge that death will probably result. Provided the necessary *mens rea* and *actus reus* can be established, the doctor's motive or the fact that the patient consented to the act causing death would be irrelevant to the issue of liability. Nor would it make any difference that the patient was in any event dying since hastening of death is sufficient to establish criminal liability.³³² Thus, upon a strict interpretation of the criminal law, doctors are potentially liable for murder if they administer pain-relieving drugs in the knowledge that death will probably result even though their intention is to alleviate the patient's pain.³³³ This conclusion obviously has far-reaching implications, having regard to the realities of medical practice and the wish of doctors to act in their patient's best interests and where possible relieve a patient's pain.

It is widely assumed that doctors are not acting unlawfully if they administer pain-relieving drugs which are likely to hasten the death of a patient, provided that the doctor's intention was to alleviate pain and not bring about the death of the patient.³³⁴ Certainly, no attempt is made to restrict this practice, or to prosecute doctors who thereby hasten the death of their patients.³³⁵

As with the issue of turning off life-support, this assumption regarding the legality of the practice of administering pain-relieving drugs which hasten death is largely based on policy considerations. Whilst the deliberate administration of a lethal dose clearly constitutes murder, many people see a distinction between palliative care and active voluntary euthanasia. Indeed, there is, quite justifiably, much resistance to characterising the practice of administering pain-relieving drugs as euthanasia.³³⁶

³²⁹ See above, 122. For the purposes of this analysis, attention will be focussed on the situation involving terminal patients. It should be noted, however, that the issue of pain-relieving drugs which shorten life may also arise in respect of non-terminally ill patients who are experiencing pain and suffering. For discussion, see D. Caswell, 'Rejecting Criminal Liability for Life-Shortening Palliative Care' (1990) 6 *J. Contemp. Health Law & Pol'y* 127, 132-133, and M. Somerville, 'Pain and Suffering at the Interfaces of Law and Medicine' (1986) 36 *U. Toronto L.J.* 286, 299-301.

³³⁰ See above, 122.

³³¹ See chapter I, 12-13, 28-29.

³³² See chapter I, 15-16.

³³³ Alternatively, the doctor may face manslaughter charges, e.g. in circumstances where the *mens rea* for murder cannot be established.

³³⁴ N. Cantor, 'A Patient's Decision to Decline Life-Saving Treatment: Bodily Integrity Versus the Preservation of Life' (1972-73) 26 *Rutgers L.Rev.* 228, 259. For the purposes of this discussion, attention is focused on the potential liability of doctors for the administration of pain-relieving drugs which may hasten death. It is, however, acknowledged that in practice it may be the case that the doctor prescribes the drugs but the nurse is left to actually administer them; see Johnstone, 249.

³³⁵ One of the rare exceptions was the case of *R v Ludwig* (unreported) (1990) *The Times* 16 March 1990, considered below, 170.

³³⁶ For example, D. Louisell, 'Euthanasia and Biathanasia: On Dying and Killing' (1973) 22 *Catholic U.L.Rev.* 723, 731; Church Assembly Board for Social Responsibility, *On Dying Well* (1975) 61. See also Caswell, 129, 131 n. 13 where he argues that palliative care is different from active euthanasia, but acknowledges that the distinction often becomes blurred. Note, however, the practice of some

Because of the widespread acceptability of the practice, and the natural desire to avoid the possibility of doctors incurring criminal liability, the criminal law is assumed not to be applicable. Furthermore, it is indisputable that many patients require pain-relieving drugs, often in high dosages. If strict criminal law principles were to be invoked, doctors would be encouraged to practice defensive medicine and this would result in tighter, less sensitive rationing of pain relief. Thus, there are powerful policy considerations which have influenced the legal characterisation of this medical practice.

The Law as Interpreted by the Courts

Whilst there have been very few cases which have raised the issue of the legality of administering pain-relieving drugs which hasten death, the case law which does exist strongly suggests that doctors will not incur criminal liability if, in appropriate circumstances, they administer drugs for pain relief which hasten death even though the doctor knew that death would probably result.

The Adams Case

The leading case in this area is the 1957 English case of *R v Adams*³³⁷ which involved the prosecution of a doctor, John Bodkin Adams, for having allegedly murdered a patient. The prosecution's case was that Adams had deliberately killed an elderly patient by the administration of large doses of morphine and heroin in order that he would benefit under her will. The defence case was that the morphine had been administered to relieve the patient's pain and it thereby raised the question of whether doctors were entitled to adopt a course of treatment which would have the effect of shortening the patient's life.³³⁸ Adams was in fact acquitted, but the case has become of lasting significance because of Justice Devlin's direction to the jury. Whilst a direction to the jury would not usually have much precedent force, this case has become something of an exception, largely because of the eminence of the judge, the significance of the legal issue under consideration, and because it is the only common law authority directly dealing with this issue.³³⁹

Justice Devlin began by pointing out that shortening life constitutes murder and that the law does not recognise a special defence of preventing severe pain. His Honour then went on to say:

But that does not mean that a doctor who is aiding the sick and the dying has to calculate in minutes or even hours, and perhaps not in days or weeks, the effect on the patient's life of the medicines that he administers or else be in peril of a charge of murder. If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.³⁴⁰

commentators to refer to the administration of pain-relieving drugs as 'indirect euthanasia'; see, for example, P. MacKinnon, 'Euthanasia and Homicide' (1983-4) 26 *Crim.L.Q.* 483.

³³⁷ (Unreported) (1957). See Palmer. The Judge in this case, Justice Devlin, as he then was, subsequently wrote a book about this trial; P. Devlin, *Easing the Passing* (1985).

³³⁸ Williams, *The Sanctity of Life and the Criminal Law*, 289.

³³⁹ The issue of administration of pain-relieving drugs has been raised in a number of later cases, see for example, *R v Lodwig* and *R v Cox*, discussed below, 170-171.

³⁴⁰ For a transcript of the instructions to the jury see Williams, *The Sanctity of Life and the Criminal Law*, 289.

Justice Devlin stressed that this was not because there is any special defence for doctors, but simply the result of interpreting cause of death in a 'common sense' way. His Honour said that if a patient's death is hastened by the administration of medical treatment, no people of common sense would say that the doctor caused her death:

They would say that the cause of death was the illness or the injury or whatever it was which brought her into hospital, and the proper medical treatment that is administered and has an incidental effect of determining the exact moment of death, or may have, is not the cause of death in any sensible use of that term.³⁴¹

Whilst the interpretation of this direction to the jury is not without difficulty,³⁴² the clearest interpretation is that it rests on the legal doctrine of causation.³⁴³ There are, however, limits on the scope of the principle expounded by Justice Devlin. It is only envisaged to apply in circumstances where the patient is beyond recovery³⁴⁴ and where the treatment administered is in accordance with proper medical practice.³⁴⁵ Within these limits, the decision has been widely cited as authority for the proposition that doctors may administer necessary pain-relieving drugs which incidentally shorten life without fear of prosecution.³⁴⁶

Although the practical effect of the decision has received considerable support, Devlin's legal basis for arriving at that decision has attracted criticism.³⁴⁷ Williams, in particular, has criticised the causation analysis on the grounds that it conceals rather than reveals the valuation that is being made.³⁴⁸ He points out that if a terminally ill patient dies from respiratory failure or pneumonia as a result of the administration of morphine, medically speaking, the death would not be caused by the underlying

³⁴¹ *Ibid.*

³⁴² For example, Smith and Hogan, 277; Beynon, 18; Kennedy and Grubb, *Medical Law* (1989) 937-939.

³⁴³ Williams, *The Sanctity of Life and the Criminal Law*, 289; Williams, *Textbook of Criminal Law*, 385; Caswell, 135. That this was in fact what Justice Devlin meant was clarified some years later when, in the course of a lecture, he stated that 'proper medical treatment consequent upon illness or injury plays no part in legal causation; and to relieve the pains of death is undoubtedly proper medical treatment.' See P. Devlin, *Samples of Law Making* (1962) 95.

³⁴⁴ The *Adams* case may, therefore, be of limited assistance in determining the criminal liability of a doctor in circumstances where life-shortening pain-relieving drugs are administered to a non-terminally ill patient. See above, n. 329 for further references.

³⁴⁵ This is clear from Justice Devlin's reference to what is 'proper and necessary' to relieve pain and to 'proper medical treatment'. On the basis of this decision, commentators have suggested that the principle would not apply where a larger amount of a pain-killing drug is administered than is necessary to reduce the pain to reasonable levels or where safer pain relief alternatives exist to the one actually chosen; see, for example A. Dix *et al*, *Law for the Medical Profession* (1988) 297; Skegg, *Law, Ethics and Medicine*, 139.

³⁴⁶ After the decision in the *Adams* case, the *Daily Telegraph* published a statement by the Director of Public Prosecutions to the effect that he did not wish to challenge Devlin's direction to the jury and that he could only agree with it; see L. Harvard, 'The Influence of the Law on Clinical Decisions Affecting Life and Death' (1983) 23 *Med. Science & Law* 157, 161.

³⁴⁷ Williams, *The Sanctity of Life and the Criminal Law*, 289-290; Caswell, 135. Other commentators have, however, supported the decision as sound; e.g. Meyers, *Medico Legal Implications of Death and Dying*, 128.

³⁴⁸ *The Sanctity of Life and the Criminal Law*, 289-290.

disease but by the morphine and he expresses some difficulty with the view that for legal purposes, the causation is precisely the opposite.³⁴⁹

An Alternative Analysis: The Common Law Doctrine of Necessity

Williams argues that the common law doctrine of necessity provides a better explanation for exempting the doctor from criminal liability.³⁵⁰ In his view, the doctrine of necessity refers to a choice between competing values in circumstances where the ordinary rule has to be departed from in order to avert some greater evil. He points out that in the context of use of pain-relieving drugs, there are situations where the doctor is faced with the choice of administering what is likely to be a fatal dose if the patient's pain is to be relieved, or leaving the patient without adequate relief. Williams argues that the doctor's actions in administering the fatal dose must be excused on the basis of the defence of necessity, since there is no way of relieving the pain without ending life.³⁵¹

The approach suggested by Williams has considerable merit. It avoids the manipulation of the doctrine of causation in order to escape the conclusion that since the doctor had foreseen that death would result from the administration of pain-relieving drugs, he or she should be legally responsible for his or her conduct. It is far preferable to deal with the issue directly and, if necessary, creating a new defence, rather than to distort existing legal principles to accommodate a desired outcome. Furthermore, since the defence of necessity is only envisaged as an exceptional departure from the normal rule, it preserves intact accepted criminal law principles regarding the *mens rea* and *actus reus* for murder.

Although conceptually sound and receiving support from some eminent jurists,³⁵² the doctrine of necessity has not, to date, been invoked by the courts to justify the administration of pain-relieving drugs which incidentally hasten death and there is case-law, particularly in the United Kingdom, which suggests that the defence of necessity is not available as a defence to murder.³⁵³

***R v Adams* and the Doctrine of 'Double Effect'**

It has been suggested by some commentators that the effect of the *Adams* case has been to incorporate into English law the doctrine of 'double effect'.³⁵⁴ This doctrine, stemming from Catholic moral

³⁴⁹ *Id.* 290. See also Devettere, 269-273 where he critically analyses the Statement of the Council of Judicial and Ethical Affairs of the American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment* March (1986) which, he argues, is based on the underlying assumption that alleviations of pain are not a cause of death.

³⁵⁰ *Id.* 286, 290. He suggests, however, that the 'common sense' doctrine of causation would help where the death of the patient is caused by a combination of the disease and the drug; 290.

³⁵¹ *Id.* 288. Other commentators are less confident that this analysis can provide clear guidance; e.g. Caswell, 136-137 where he expresses the concern that the whilst the availability of the defence of necessity may help deal with isolated cases it does not provide clear guidance to doctors.

³⁵² Williams, *The Sanctity of Life and the Criminal Law*, 284, 286-8, 290; G. Moore, 'The Common Law Doctrine of Necessity' in Church Assembly Board for Social Responsibility, *Decisions About Life and Death* (1965) 49, 50.

³⁵³ *R v Dudley* (1884) 14 Q.B.D. 273; *R v Howe* (1987) 85 Crim. App. R. 32, 39-41. Compare with the emerging position in Australia where there appears to be greater willingness to allow the defence of necessity in cases of murder; see *Howard's Criminal Law* (5th ed., 1990 by B. Fisse) 557-558.

³⁵⁴ See I. Kennedy, *Treat Me Right* (1988) 325; Kennedy and Grubb, 938 for discussion of this possibility.

theology,³⁵⁵ is essentially based on a distinction between results which are *intended* and those which are merely *foreseen* as a non-intended consequence of one's action.³⁵⁶ Under this principle, it may sometime be morally legitimate to act while foreseeing, but not intending, an undesirable result of one's action, but it is never morally legitimate to act with the intention of producing that result.³⁵⁷ Thus, a doctor can legitimately administer pain-relieving drugs which hasten death if his or her primary aim is to relieve the patient's suffering though foreseeing that this may indirectly hasten the death of the patient. However, a doctor may never deliberately give a patient an overdose with the intention of killing him or her.

One possible interpretation of Justice Devlin's direction to the jury in the *Adams* case is that in circumstances involving administration of pain-relieving drugs, a doctor will not be criminally liable unless he or she actually intended to bring about the death.³⁵⁸ However, the difficulty with this interpretation is that it is inconsistent with strict criminal law principles. As Williams observes:

There is no legal difference between desiring or intending a consequence as following from your conduct, and persisting in your conduct with the knowledge that the consequence will inevitably follow from it, though not desiring that consequence. When a result is foreseen as certain it is the same as if it were desired or intended.³⁵⁹

Although the doctrine of double effect is sometimes invoked to justify the administration of pain-relieving drugs which incidentally hasten death,³⁶⁰ the reality of the matter is that the distinction between *intending* and merely *knowing* that death will probably result from one's acts is a distinction that has never made a difference to the criminal law.³⁶¹ According to well established principles, provided the defendant subjectively knew that the administration of drugs would be life-threatening, criminal liability for homicide can theoretically be established even though the doctor's primary intention was to relieve the patient's suffering.

The Law in the United Kingdom in the Light of the *Adams* Case

Whilst the analytical basis of the *Adams* case may be open to interpretation, it does appear to have become authority, at least in the United Kingdom, for the following proposition; a doctor may lawfully administer to a patient *in extremis* pain-killing drugs in such quantities to relieve the

³⁵⁵ For a contemporary statement of the position of the Catholic Church see Pope Pious XII, 'Religious and Moral Aspects of Pain Prevention in Medical Practice' (1957) 88 *Ir. Ecclesiastical Rec.* 193, 193-209.

³⁵⁶ For discussion of the principle of double effect see G. Kelly, *Medico-Moral Problems* (1958) 12-16; S. Uniacke, 'The Doctrine of Double Effect' (1984) 48 *The Thomist* 188. For a critical analysis of the principle of double effect see H. Kuhse, *The Sanctity of Life Doctrine in Medicine* (1987) 83-165.

³⁵⁷ S. Potts, 'Looking for the Exit Door: Killing and Caring in Modern Medicine' (1988) 25 *Hous.L.Rev.* 493. In order for the principle of double effect to apply, certain conditions must be fulfilled; 1) the action, considered by itself and independently of its effects, must not be morally evil; 2) the evil effect must not be the means of producing the good effect; 3) the evil effect is sincerely not intended, but merely tolerated; 4) there must be a proportionate reason for performing the action, in spite of its evil consequences. See Kelly, 13-14.

³⁵⁸ Kennedy and Grubb, 938.

³⁵⁹ *Sanctity of Life and the Criminal Law*, 286. See also Kennedy and Grubb, 938.

³⁶⁰ For example, B.M.A. Working Party Report, *Euthanasia*, 40; B. Lo, 'Euthanasia - The Continuing Debate' (1988) 149 *Western J.Med.* 211.

³⁶¹ *R v Crabbe* (1985) 58 A.L.R. 417; *R v Moloney* [1985] A.C. 905; *R v Nedrick* [1986] 3 All E.R. 1025.

patient's suffering, even though the doctor knows that the patient is likely to die as a result, subject, however, to the proviso that those drugs are administered for the purpose of pain relief and not to kill the patient. Leaving aside for the moment policy considerations which clearly favour doctors being able to administer appropriate pain relief, it is readily apparent that the *Adams* case represents quite a remarkable exception to existing criminal law principles. It is well established that motive or desire is not normally relevant to preclude the imposition of criminal liability for conduct which causes death, in circumstances where those consequences were intended or at least foreseen. Given the significance of this departure from criminal law principles, it is, perhaps, surprising that there has not been a clearer statement of the basis of the exception. Indeed, a number of commentators have questioned the authority of the *Adams* case and have suggested that there may still be some uncertainty about the law as it concerns the use of pain-killing drugs which incidentally shorten life.³⁶²

There have been a number of cases decided in the United Kingdom since the *Adams* case, dealing with defective newborns, which tend to support the view that doctors may lawfully administer pain-relieving drugs which have the effect of hastening the patient's death. The first of these cases was *R v Arthur*³⁶³ involving the prosecution of Dr Leonard Arthur, for the attempted murder of a Down's syndrome child, by withholding food and administering a narcotic analgesic. On the evidence, there was some dispute whether the drug was administered for the purpose of relieving pain or as an appetite suppressant. Farquharson J. stated that the administration of a drug by a doctor when it is necessary to relieve pain is a proper medical practice even when the doctor knows that the drugs will cause the patient's death.³⁶⁴ A more recent decision along similar lines was reached in *In re C (A Minor) (Wardship: Medical Treatment)* arising in the court's wardship jurisdiction.³⁶⁵ The baby in this case was born prematurely suffering from hydrocephalus, with severe brain damage and physical disability. For reasons unconnected with the child's medical condition she had been made a ward of the court and the matter came before the court by way of application regarding the future medical treatment of the baby. The court accepted medical opinion that the child's condition was hopeless and held, having regard to the best interests of the child, that it was entitled to approve recommendations designed to ease the baby's suffering rather than to prolong her life.³⁶⁶ The English Court of Appeal subsequently confirmed this approach.³⁶⁷ This approach has continued in the case of *In re J (Wardship: Medical Treatment)*³⁶⁸ also arising in the court's wardship jurisdiction. The baby in this case was profoundly handicapped but not terminally ill and the question at issue was whether the court

³⁶² For example, Lord Edmund Davies, 'On Dying and Dying Well: Legal Aspects' (1977) 70 *Proc. Royal Soc. Med.* 71, 74; Trowell, 35-36; Caswell, 137.

³⁶³ (Unreported) (1981) (discussed by M. Gunn and J.C. Smith, 'Arthur's Case and the Right to Life of a Down's Syndrome Child' (1985) *Crim.L.Rev.* 705.)

³⁶⁴ Transcript, 19 as cited in Gunn and Smith.

³⁶⁵ [1989] 3 W.L.R. 240.

³⁶⁶ (Unreported) 14 April 1989 per Ward J.

³⁶⁷ [1989] 3 W.L.R. 240. Some concern had arisen concerning the wording of the trial judge's original order which was to the effect that the baby should be 'treated to die' and contained specific details regarding medical treatment. The controversial wording had been amended by the judge by the time the matter came before the Court of Appeal and the court upheld the trial judge's decision except in so far as it sought to give specific instructions about medical treatment.

³⁶⁸ [1991] 2 W.L.R. 140

could sanction the withholding of future resuscitation by mechanical ventilation. Lord Donaldson M.R., who delivered the principal judgment for the court, expressed the following view:

What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which *as a side effect* will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so.³⁶⁹

Although these comments were made in a civil case concerning the medical treatment of a minor, they are potentially of wider relevance and appear to endorse the use of pain-relieving drugs which may incidentally hasten death on the basis of the doctrine of double effect.

Notwithstanding these cases, the present immunity of doctors from prosecution for the practice of administration of pain-relieving drugs which may hasten death rests on the somewhat tenuous authority of the *Adams* case and the compliance of prosecuting authorities with this state of affairs. A number of recent prosecutions of doctors in England has shown that the legal position of doctors in administering pain-relieving drugs is far from certain.³⁷⁰ In 1990, Dr Thomas Lodwig had been charged with the murder of a 48 year old male patient who was in the terminal stages of cancer. The patient had been receiving heroin in increasing dosages for the purposes of pain relief. However, in the days preceding his death, this regimen was no longer effective and the patient was suffering severe and uncontrollable pain. In an attempt to relieve the patient's distress, Dr Lodwig gave the patient a mixture of potassium chloride and lignocaine. The patient died a few minutes later. Potassium chloride is known to be lethal, but there was some evidence to suggest that when used in combination with pain-killers, it could accelerate their pain-killing effect.³⁷¹ Dr Lodwig was committed for trial but when the matter came before the court the prosecution offered no evidence against him and the judge directed that a verdict of not guilty be entered.³⁷² Although the prosecution of Dr Lodwig was eventually dropped, the case has certainly highlighted the legal vulnerability of doctors in these circumstances.³⁷³

The issue of pain-relieving drugs was also raised in the recent prosecution against Dr Cox referred to earlier.³⁷⁴ Dr Cox had administered a large and undiluted dose of potassium chloride to his patient, (a

³⁶⁹ *Id.* 149. (Emphasis in the original.)

³⁷⁰ *R v Lodwig* (unreported) (1990) *The Times* 16 March 1990. For discussion see D. Brahm, 'The Reluctant Survivor' (1990) 140 *New L.J.* 586, 587.

³⁷¹ Two eminent doctors from St. Bartholomew's Hospital, where Dr Lodwig had completed his training, had been involved in research regarding the use of potassium chloride with pain-killers to accelerate their analgesic effect and reported encouraging results from their clinical trials; *The Times* 16 March 1990.

³⁷² The principle reason that the prosecution was dropped was because of uncertainty regarding the cause of death; *The Times* 16 March 1990.

³⁷³ Recent prosecutions for manslaughter brought against doctors in the United Kingdom based upon criminal negligence is further evidence that doctors are not immune from liability; G. Korgaonkar and D. Tribe, 'Medical Manslaughter' (1992) 136 *Sol.J.* 105.

³⁷⁴ See above, 126-127.

drug which has no pain-killing properties) from which the patient died within minutes. Cox had argued that his primary intention in administering the drug was not to kill the patient but to relieve her suffering. However, this was rejected by the court and the jury's verdict of guilty was premised on the assumption that he had intended to kill the patient, albeit for merciful motives.

The Position in Australia and Other Jurisdictions

The situation in Australia is even less clear, since there are no Australian authorities expressly dealing with this issue.³⁷⁵ In practice, however, no prosecutions have arisen, notwithstanding that doctors are frequently taking steps to ease their patient's pain which incidentally shorten life.³⁷⁶ If the matter were to come before the Australian courts, the *Adams* case would be merely persuasive authority. Nevertheless, the courts would probably be inclined to take the view that the *Adams* case also represents the position in Australia, particularly in light of the eminence of the judge and the fact that the law as set down in that case has been widely accepted as an ethical statement.³⁷⁷

There may, however, be some difficulty in adopting the *Adams* decision in the Australian Code jurisdictions which have a provision which unequivocally states that a person who is responsible for hastening the death of another is deemed to have killed that person.³⁷⁸ Concern about the legal position in Western Australia (one of the Code jurisdictions) led the Western Australia Law Reform Commission to recommend that legislation be introduced protecting doctors from liability for administering drugs or other treatment for the purpose of controlling pain, even though the drugs or other treatment may incidentally shorten the patient's life, provided that the consent of the patient is obtained and that the administration of the drug or treatment is reasonable in all the circumstances.³⁷⁹ In Queensland, the Criminal Code Review Committee has also recommended that the Queensland Code contain a provision specifically providing that the administration of reasonable palliative care will not attract criminal liability, even if it cuts short the patient's life.³⁸⁰ This recommendation was based on the recommendations of the Law Reform Commission of Canada.³⁸¹ There has, to date, been no legislative implementation of these recommendations.

As an alternative to the *Adams* case, a possibility which may be explored in the future is the exception referred to in *R v Crabbe*.³⁸² Although only *obiter*, it was suggested in a joint judgment of

³⁷⁵ One possible interpretation of the case of *R v Lim* (unreported) 25 Jan 1989, P.S. W.A. (see above, n. 64) is that the morphine which had allegedly caused the patient's death was administered for the purposes of pain relief. However, the evidence was very much conflicting and the court did not specifically address itself to the question of the doctor's legal liability in these circumstances.

³⁷⁶ See above, 122.

³⁷⁷ See also Professor D. Lanham, the *Age* 4 March 1992 (letter).

³⁷⁸ Qld. s. 296; Tas. s. 154(d); W.A. s. 273. (There is no equivalent provision in the Northern Territory *Criminal Code*). In the Tasmanian *Criminal Code* there is a provision which specifically saves common law defences except in so far as they are altered by or inconsistent with the Code; see s. 8.

³⁷⁹ *Medical Treatment for the Dying* (1991) 25-27.

³⁸⁰ Queensland Criminal Code Review Committee Interim Report *First Interim Report of the Criminal Code Review Committee* (1991) clause 69.

³⁸¹ Report No. 20, *Euthanasia, Aiding Suicide and the Cessation of Treatment* (1983) 22-23 and restated in the later report, Report No. 30, *Recodifying Criminal Law* (1987) 185-186.

³⁸² (1985) 58 A.L.R. 417.

the High Court that not every fatal act done with the knowledge that death or grievous bodily harm will probably result is murder.³⁸³ The court went on to say that the act may be lawful, that is, justified or excused by law, and gave the example of a surgeon who performs a hazardous but necessary operation, in circumstances where he or she could foresee that the patient's death was probable.³⁸⁴ After raising this possibility the court stated that this question need not be discussed in the present case, but did, with apparent approval, refer to academic writers who have pointed out that in deciding whether an act is justifiable its social purpose or social utility is important.³⁸⁵ In light of the comments in this case it is possible, at least for the purposes of the Australian common law jurisdictions, that the courts would accommodate the practice of doctors administering pain-relieving drugs which may incidentally hasten the patient's death within this concept of a socially justifiable risk.³⁸⁶ However, there is admittedly a significant difference between the taking of a risk for the purpose of saving life (e.g. performing a hazardous operation) and a situation where a doctor causes the patient's death in an attempt to relieve pain.³⁸⁷ With the exception of the Northern Territory,³⁸⁸ there is no corresponding concept of lawful justification under the Criminal Codes in Australia. South Australia is the only Australian jurisdiction which presently has legislation offering some tangible protection to doctors from liability for the death of a patient following the administration of pain-relieving drugs, in circumstances where the drugs are administered with the consent of the patient. Section 8(1)(b) of the *Consent to Medical and Dental Procedures Act* 1985 (S.A.) provides that no criminal or civil liability shall be incurred in respect of the carrying out of a medical or dental procedure³⁸⁹ on a person with his or her consent if the procedure is reasonably appropriate in the circumstances having regard to the prevailing medical or dental standards and is carried out in good faith and without negligence.³⁹⁰

Although no American cases have specified the drug exception to homicide, the practice of administering drugs to relieve pain, even if it hastens death, is generally accepted as legal in the United States, despite the fact that it might technically be regarded as homicide.³⁹¹ Cantor writes:

There is a tacit understanding that prosecution would never be undertaken, even if causal connection between the analgesic and death could be established.

³⁸³ *Id.* 470.

³⁸⁴ *Ibid.*

³⁸⁵ *Ibid.*

³⁸⁶ See also Riordan, 66.

³⁸⁷ *Ibid.*, where reference is made to the controversy as to whether the deliberate taking of life is ever justified.

³⁸⁸ Section 31(2) of the *Criminal Code* 1983 (N.T.) provides that there will be no liability where the accused did not intend to cause death, if a reasonable person, similarly circumstanced, would have proceeded with the conduct.

³⁸⁹ 'Medical procedure' is defined in s. 4 to mean any procedure carried out by, or pursuant to directions given by, a medical practitioner in the course of practice as a medical practitioner.

³⁹⁰ See also the recommendations made by the South Australian Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying, *Second Interim Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1992) 8-9, discussed in chapter VII at?

³⁹¹ S. Akers, 'The Living Will: Already A Practical Alternative' (1976-77) 55 *Tex.L.Rev.* 665, 671; the President's Commission Report, 78-82; Cantor, *Legal Frontiers of Death and Dying*, 35.

[M]edical practice has won de facto legal acceptance because of widespread acknowledgment of its humane grounding.³⁹²

Similarly in Canada, no cases have come before the courts³⁹³ and although the position remains uncertain,³⁹⁴ it is generally assumed that doctors would escape liability in these circumstances.

A Critique of the Present Law

It should be stressed from the outset, that there can be no real dispute about the social desirability of the practice of administering pain-killing drugs and the recognised need for doctors to be able to provide patients with adequate pain relief. Thus, the following critique of the present legal position is not in any way aimed at changing current medical practice. Rather, the object is to demonstrate that the assumptions regarding the legality of this practice are irreconcilable with established criminal law principles and that the law is clearly being manipulated in order to sanction what is widely regarded as legitimate medical practice.

Resort to Legal Fictions

Whichever analysis of the *Adams* case is adopted, (i.e. based on either the causation arguments or the principle of double effect,) the case is completely contrary to established legal authority. As Justice Devlin himself acknowledged,³⁹⁵ under ordinary criminal law principles the hastening of an inevitable death is murder. Whilst there may well be practical difficulties in establishing causation in cases where a patient has died following the administration of pain-killing drugs, it is simply legal sophistry to say that this is never the relevant cause of death in law. Similarly, with regard to the double effect doctrine, the distinction between intending to kill and merely foreseeing that death will probably result from one's acts has never been relevant for the purpose of establishing criminal liability. The reality is that on accepted principles of causation and intention, a doctor who administers pain-relieving drugs which he or she knows will probably hasten the patient's death, does, in a legal sense intend the death of the patient and has in fact caused that death. The fact that the doctor's motive was to relieve the patient's pain, or that the patient had consented to the treatment, would not protect a doctor from criminal liability.

Thus, there is clearly a wide gulf between strict criminal principles and the law as presently interpreted with respect to the administration of pain-killing drugs; although strictly speaking, the practice constitutes murder, the law has acknowledged and acquiesced in the practice.³⁹⁶ It is interesting to

³⁹² Cantor, *Legal Frontiers of Death and Dying*, 35.

³⁹³ See Caswell, 139 where he notes that one doctor had been charged with first-degree murder in such a case, but the case was never tried because the doctor left Canada and the Canadian government could not obtain the doctor's extradition. See also B. Sneide(r)man, 'Euthanasia in the Netherlands: A Model for Canada?' (1992) 8 *Humane Med.* 104, 113 where he notes that a Vancouver physician, who had administered a fatal dose of morphine to two patients who had been 'near death' was not prosecuted.

³⁹⁴ Caswell, 137 and note also the findings and recommendations of the Canadian Law Reform Commission, see above, n. 381. The position appears to be the same in New Zealand.

³⁹⁵ Palmer, 375 where he cites Justice Devlin's summing up to the jury; 'It did not matter whether Mrs Morrell's death was inevitable and that her days were numbered. If her life were cut short by weeks or months it was just as much murder as if it were cut short by years.'

³⁹⁶ Cantor, *Legal Frontiers of Death and Dying*, 35.

observe how the courts have almost surreptitiously manipulated the law to accommodate this practice, without clearly and unequivocally stating an exception to established criminal law principles. Indeed, one detects a distinct reluctance to openly deal with the matter and provide an appropriate defence in respect of this practice.³⁹⁷ This is, perhaps, understandable, in that the courts do not want to be seen creating special defences for doctors or to be sanctioning what may be regarded by some as medical euthanasia. Nevertheless, these considerations do not justify the use of illogical legal fictions. It is simply not valid to reinterpret or gloss over established principles in order to produce a desired result. The real danger is that manipulation or distortion of established legal principles tends to undermine the credibility of the law and threatens to bring it into disrepute.

Unworkable Distinctions

The other major criticism of the prevailing legal position is that it involves very fine, and arguably unworkable, distinctions. On the authority of the *Adams* case, there is a distinction between the administration of drugs for pain relief and which are known to be likely to hasten the death of the patient, and the administration of a lethal dose intended to kill the patient; the former is lawful, whereas the latter constitutes the crime of murder. Indeed, the terminology used is in itself significant; the incidental 'shortening of life' or 'hastening of death' is often used in contradistinction to 'killing' the patient, thereby concealing the reality that the administration of drugs for pain relief may equally kill a patient.

Although the distinction between killing and merely hastening death in the process of relieving the patient's pain has gained considerable currency, the dividing line can be impossibly fine. Ultimately it seems to depend on what was in the mind of the doctor when he or she administered the drugs in question - was it to relieve the patient's pain or to kill the patient? Whilst this may, in many instances, be a fairly straightforward proposition, circumstances can be envisaged which tend to blur the distinction. For example, what if it is necessary to kill the patient in order to relieve his or her pain? It might be suggested that in these circumstances the doctor's primary intention is to relieve the patient's pain and the hastening of death is simply an incidental consequence. Realistically, however, it is more likely that the doctor's intention in these circumstances is to kill both the pain and the patient.

Furthermore, if administering drugs to relieve pain is permissible despite the possibility that it may hasten the death of the patient, but administering drugs with the intention of euthanasing a patient is not, it is possible that some doctors will perform active euthanasia under the guise of pain relief, and there is evidence to suggest that this does in fact occur.³⁹⁸ Thus, as Williams observes, since many of the available analgesics have the effect of hastening death, a situation of benevolent hypocrisy prevails.³⁹⁹

³⁹⁷ Skegg, *Law, Ethics and Medicine*, 78.

³⁹⁸ Maguire, 37; Johnstone, 263.

³⁹⁹ G. Williams, 'Euthanasia' (1970) 63 *Proceedings for the Royal Society of Medicine* 663, 665.

Uncertainty in Practice

Another major criticism of the present legal position is that it is still precariously uncertain, particularly in Australia and other jurisdictions where the issue has not directly come before the courts. Whilst it is more than likely that the *Adams* approach would be accepted, this cannot be guaranteed. In a climate of uncertainty regarding the legality of administering pain-relieving drugs which may hasten death, there is the risk that doctors may be unwilling to provide adequate pain relief, thereby forcing patients to endure unnecessary pain and suffering.⁴⁰⁰

It is clearly undesirable that doctors should face the possibility of criminal liability as a result of acting humanely to relieve a patient's pain. Some commentators have stressed that, in any event, it is unlikely that these practices are discovered, or if discovered, that they can be proved and successfully prosecuted.⁴⁰¹ This may well be so but it must be wondered whether the present situation is satisfactory. Palliative care and adequate pain relief are of such importance that doctors ought to be able to confidently administer to the needs of their patients without raising the spectre of criminal liability. It would be far preferable if there were a clearer statement of the legal exception which protects doctors from liability in circumstances where drugs are administered for the purpose of pain relief, but which may have the effect of hastening the death of the patient.⁴⁰²

Conclusion

The object of this chapter has been to highlight the serious discrepancies which exist between the strict legal position and the position in practice with regard to active voluntary euthanasia and where relevant, assisted suicide, in order to demonstrate the inadequacies of the present law and the need for re-evaluation of the law's approach to these issues. It has been shown that notwithstanding the criminal law prohibition of active voluntary euthanasia as murder, there is significant evidence to indicate that this practice does occur. However, the likelihood of a doctor being prosecuted and convicted of the murder of a patient is fairly remote. The same holds true for doctor-assisted suicide; although there is incontrovertible evidence that this practice occurs there are virtually no prosecutions. Analysis of cases of mercy killing outside of the medical context reveals that these cases are generally dealt with extremely leniently in the criminal justice system and there is every indication that a doctor who is prosecuted for having performed active euthanasia at a patient's request or for having assisted the suicide of a patient would also be dealt with sympathetically.

⁴⁰⁰ See also Caswell, 138; Law Reform Commission of Western Australian Report, 25-26.

⁴⁰¹ See, for example, Church Assembly Board for Social Responsibility, *On Dying Well*, 58. In circumstances where the patient is suffering from a terminal condition and is in a debilitated state it will often be difficult to establish that the patient died from the drugs rather than the underlying illness. Difficulties are compounded in circumstances where the patient has become habituated to the use of a drug, with the result that increased dosages would have the same effect as a standard dose would have on a normal patient.

⁴⁰² Examples of suggested legislative statements creating an exception from liability can be found in the recommendations of the West Australian Law Reform Commission Report, 26-27 and the Canadian Law Reform Commission, see above, 171.

It has also been shown that other aspects of medical practice, such as turning off life-support or the administration of drugs knowing that they will cause death, which, although on strict legal principles attract criminal liability for murder, have been deliberately characterised in such a way as to avoid such liability.

It is, therefore, evident that significant inconsistencies exist between the law in theory and the law in practice. In effect, the criminal justice system has acquiesced in the practice of active voluntary euthanasia by manipulating and distorting legal principles to avoid the full rigours of the criminal law. It has been argued that the present position is most unsatisfactory and threatens to undermine the credibility of the law. There is a need for greater honesty and clarity in this area to overcome the existing discrepancies and anomalies. It must be acknowledged that active voluntary euthanasia is already being performed, albeit surreptitiously, and that there are other medical practices, which, although widely accepted, are strictly speaking contrary to established criminal law principles. The law appears to condone some medical 'acts' which hasten the death of a patient such as the removal of artificial life-support and the administration of drugs for pain relief yet, theoretically at least, maintains a strict legal prohibition on the practice of active voluntary euthanasia. Given the obvious similarities between these various medical acts in terms of outcome and intention, and arguably, also morality, one may well question whether the line between lawful and unlawful conduct has been appropriately drawn. Does it really make sense for the law to permit a patient to direct the discontinuance of artificial life-support and thereby bring about an earlier death, yet deny the patient direct assistance in the form of a lethal dose? Arguably not, and there are strong arguments to suggest that established criminal law principles with regard to homicide are simply inappropriate in the contemporary context of medically administered active voluntary euthanasia. The fact that doctors are unlikely to be exposed to liability, or if exposed, will almost certainly be dealt with leniently, is not an adequate response. It is quite unacceptable that doctors who feel compelled to respond to a patient's request for active euthanasia presently run the risk of serious criminal liability. If society has reached the stage where such medical conduct is regarded as acceptable and not deserving of punishment, this should be more directly reflected in our laws rather than doctors and those involved in the administration of the criminal justice system having to rely on subterfuge and questionable techniques of liability avoidance.

Consideration also needs to be given to the rights and interests of patients. So long as active voluntary euthanasia remains an illegal and covert practice, its administration will inevitably be inconsistent, and it will not equally be available to all who seek it. There is also the very real concern that whilst the practice of active voluntary euthanasia exists but remains unregulated, patients' rights and interests are not adequately protected.

Since the law already permits certain acts which cause death in connection with implementing the withdrawal of life-support and in administering pain-relieving drugs, it is, in fact, only a small step to say that, in some limited circumstances, active voluntary euthanasia should also be allowed. In light

of the available evidence that death-inducing acts are already taking place, it would be preferable to formalise current practices, in order to regulate and protect against abuse and to overcome discrepancies between legal theory and practice. The present connivance and hypocrisy of the law is no credit to the legal profession and certainly leaves doctors in an untenable position. There is a strong case for the law to directly confront the question of active voluntary euthanasia, for instilling greater clarity and certainty in this area, and to provide appropriate protection for doctors, who act *bona fide* in their patients' best interests. However, the question of reform is not just a legal issue, and there are obviously a whole host of considerations to be taken into account in determining whether the law should be changed so as to allow doctors to perform active euthanasia at the request of a patient. It is to this issue that attention will turn in the following chapter dealing with the euthanasia debate.

CHAPTER V

THE EUTHANASIA DEBATE

Introduction

The object of this chapter is to review and critically analyse the 'euthanasia debate'.¹ The debate regarding the practice and legalisation of active voluntary euthanasia has existed for many years² and there is already a wealth of literature on this subject from a variety of disciplines, including law, medicine, theology, and philosophy. Consequently, this chapter is primarily in the form of a literature review to consider the principal arguments that have been advanced both for and against the legalisation of active voluntary euthanasia. Although many of the issues are legal in nature, this chapter necessarily involves consideration also of non-legal arguments. An attempt will be made to critically analyse the competing arguments and arrive at some conclusion as to whether active voluntary euthanasia should be legalised. It must be emphasised that the principal concern here is what the law ought to be rather than the question of the morality of active euthanasia apart from the law. For the purposes of this analysis, the issue of active voluntary euthanasia will be considered in general terms only, without reference to any particular proposal for legalisation, leaving for later consideration how legalisation could be most appropriately effected.³

It must be recognised from the outset that the debate about active voluntary euthanasia is in many respects indeterminable and intractable. Euthanasia is a controversial subject which inevitably provokes intense emotional debate and gives rise to strong convictions which do not readily lend themselves to consensus. Where such conflicts of values exist, with seemingly little middle ground, it is unlikely that a resolution can be reached which will meet with universal approval. Indeed, in a society with a plurality of widely differing yet moral views and convictions, one cannot expect unanimity on this issue.

Notwithstanding the difficulties in this area, there is a pressing need for the issue of active voluntary euthanasia to be addressed. Attitudes to death have been changing. What has traditionally been a taboo subject is now increasingly being openly discussed and a more personal conception of death is

¹ Because of the close relationship between active voluntary euthanasia and doctor-assisted suicide much of the discussion in this chapter also applies to doctor-assisted suicide.

² For commentators dealing with the historical aspects of the euthanasia debate see G. Gruman, 'An Historical Introduction to Ideas About Voluntary Euthanasia' (1973) 4 *Omega* 87; J. Behnke and S. Bok, *Dilemmas of Euthanasia* (1975) 28-44; R. Weir, *Abating Treatment with Critically Ill Patients* (1989) 220; I. van der Sluis, 'The Movement for Euthanasia, 1875-1975' (1979) 66 *Janus* 131. See also the Introduction to this thesis, 1.

³ See chapter IX.

emerging. The medicalisation of terminal care and increasing attention to patient rights generally, have also encouraged greater interest in the euthanasia debate. Public opinion appears to be increasingly in favour of permitting active euthanasia in carefully regulated circumstances, and the campaign for reform of the law is gathering momentum.⁴ Now, more than ever, there is a need to dispassionately examine the euthanasia debate and determine whether active voluntary euthanasia should be legalised.

This chapter is divided into three parts: part I dealing with the case for legalising active voluntary euthanasia, part II dealing with the case against legalisation, and part III examining the legal philosopher's debate; the role of the criminal law.

PART I

The Case For Legalisation of Active Voluntary Euthanasia

There have, over the years, been many proponents of active euthanasia, who have campaigned for its legalisation including eminent figures such as Williams⁵ and Fletcher.⁶ Whilst all euthanasia proponents are in favour of the legalisation of active euthanasia, a difference of opinion exists as to whether it should be strictly limited to voluntary euthanasia, or whether, in some circumstances non-voluntary (as distinct from involuntary) euthanasia should also be permitted.⁷ Consistent with the object of this thesis, the arguments considered in this chapter will only be dealing with active voluntary euthanasia.

Self-Determination: An Argument from Liberty

The main argument in support of the legalisation of active voluntary euthanasia is based on the principle of autonomy or the right to self-determination.⁸ According to this principle, each person has

⁴ See chapters VI and VII.

⁵ See, for example, G. Williams, *The Sanctity of Life and the Criminal Law* (1958); G. Williams, 'Euthanasia' (1973) 41 *Medico-Legal J.* 14.

⁶ See, for example, J. Fletcher *Morals and Medicine* (1979) 172-210, J. Fletcher, 'Ethics and Euthanasia' (1973) 73 *Am.J. Nursing* 670. Other notable commentators who have contributed to the debate in favour of active euthanasia include M. Kohl, (ed.) *Beneficent Euthanasia* (1975); A. Morris, 'Voluntary Euthanasia' (1970) 45 *Wash.L.Rev.* 239; A. Levison, 'Voluntary Mercy Deaths' (1961) 8 *J. Forensic Med.* 57.

⁷ For example, Kohl; Williams, *The Sanctity of Life and the Criminal Law*, 310-312; R. Young, 'Voluntary and Non-Voluntary Euthanasia' (1976) 59 *The Monist* 264; J. Rachels, *The End of Life* (1986); P. Singer, *Practical Ethics* (1979) 127-157. See the Introduction to this thesis, 6 for definition of these terms.

⁸ H. Leenen, 'The Right to Health Care and the Right of Self-Determination' (1982) 7 *Jus Medicum* 7; G.P. Smith, 'All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?' (1989) 22 *U.Calif., Davis* 275; J. Arras, 'The Right to Die on the Slippery Slope' (1982) 8 *Social Theory & Practice* 285, 293-294. Other commentators have, however, taken the view that the right to self-determination does not extend to allowing an individual to choose to be killed; e.g. D. Callahan, 'Can We Return Death to Disease?' (1989) 19 *Hastings Center R.* 4, 5; D.

value and is worthy of respect, is the bearer of basic rights and freedoms, and is the final determiner of his or her destiny.⁹ Proponents argue that an individual who has decision-making capacity, has the right to control his or her own body and should be able to determine how and when he or she will die as long as this does not interfere with the rights of others. It is this human self-determination, the capacity of individuals to choose and pursue their particular life-plan, which is said to give persons their special moral status¹⁰ and is an essential component of the dignity that attaches to rational personhood.¹¹

A further dimension of the principle of autonomy or self-determination is that its exercise should not interfere with the rights of others. Proponents argue that maintenance of the present legal prohibition on active voluntary euthanasia is an unjustifiable infringement on the liberty of those persons who would choose to be killed.¹² They argue that in order to uphold the patient's interest in self-determination, doctors should be free to act upon the request of an informed and mentally capable patient for active voluntary euthanasia without fear of criminal liability.

If the principle of self-determination is accepted as the appropriate foundation for the legalisation of active voluntary euthanasia there would be no need to objectively examine quality of life considerations - indeed, it would be quite inappropriate to do so.¹³ Any attempt to impose a qualitative assessment of the patient's life as a basis for active euthanasia would be a violation of the requirement of justice¹⁴ and would be completely contrary to the principle of patient autonomy. Different patients will inevitably have different goals and values which can best be respected by giving effect to the patient's interest in self-determination and allowing the patient to make decisions based on his or her own quality of life assessment.¹⁵ Thus, the sole consideration should be the patient's choice, based on the patient's *subjective* assessment of his or her circumstances whether motivated by a fear of pain, suffering, dependency or whatever.

Further, it must be understood that strict adherence to the notion of self-determination necessarily dispels any reliance upon utilitarian principles as a basis for active euthanasia. The arguments of some proponents for the legalisation of active euthanasia rest on a form of utilitarian humanism which

Shewmon, 'Active Voluntary Euthanasia: A Needless Pandora's Box' (1987) 3 *Issues Law & Med.* 219, 221.

⁹ R. Gula, 'Moral Principles Shaping Public Policy on Euthanasia' (1990) 14 *Second Opinion* 73, 78.

¹⁰ J. Rawls, 'Rational and Full Autonomy' (1980) 77 *J. Phil.* 524; H. Kuhse, 'Active and Passive Euthanasia - Ten Years into the Debate' (1986) 1 *Euthanasia Rev.* 108, 115; D. Richards, 'Constitutional Privacy, the Right to Die and the Meaning of Life' (1981) 22 *Wm. & Mary L.Rev.* 327, 412-414.

¹¹ A. Dyck, 'An Alternative to the Ethics of Euthanasia' in R. Weir, (ed.) *Ethical Issues in Death and Dying* (1977) 281, 285.

¹² Euthanasia Society, *A Plan for Voluntary Euthanasia* (1962) 5-9.

¹³ An analogy can be drawn here with developments in relation to passive euthanasia; it is now widely recognised that it is inappropriate for the patient's right to refuse treatment to depend upon an objective assessment of the quality of the patient's life. See chapter II, 54-57.

¹⁴ G. Grisez and J.M. Boyle, *Life and Death with Liberty and Justice* (1979) 214-250.

¹⁵ H. Kuhse, 'Taking Patient's Rights and Interests Seriously', submission to the Victorian Social Development Committee Inquiry into Options for Dying With Dignity (1986). This proposition is well accepted in the context of the common law right to refuse treatment.

demands the decriminalisation of certain acts of euthanasia and suicide.¹⁶ On pure utilitarian principles, active euthanasia would be justified in circumstances where the patient, and persons involved in the care of the patient, are suffering a balance of pain over pleasure and where the killing of the patient would, on utilitarian calculations, produce the greatest good for the greatest number. However, this reveals a fundamental weakness in utilitarian arguments as a basis for strictly voluntary euthanasia, in that they apply with equal force to cases of involuntary euthanasia - a practice which must be unequivocally deplored. According to utilitarian principles, provided there is a balance of pain over pleasure, active euthanasia would be justified if it could maximise benefits overall, regardless of whether the patient can or would give consent.¹⁷ Thus, the interests of the individual patient are subordinated to the interests of the majority. Because of this possible manipulation of utilitarian arguments towards non-voluntary and involuntary euthanasia, utilitarianism ought to be rejected as a moral theory justifying active voluntary euthanasia.¹⁸ In contrast, however, the autonomy-based principle of self-determination, essentially anti-utilitarian in nature, is at no risk of extension to non-voluntary or involuntary forms of killing and therefore constitutes the only acceptable basis for the legalisation of active voluntary euthanasia.

The Patient's Right to Refuse Treatment: Is there a Morally Valid Distinction between Passive and Active Euthanasia?

In support of arguments based on the patient's interest in self-determination, proponents frequently draw attention to the inconsistency of the present law which permits a patient to induce an earlier death by refusing treatment, yet categorically prohibits a patient from seeking active assistance in dying.¹⁹

As outlined in chapter II, the patient's interest in self-determination finds expression in the important legal right to bodily integrity.²⁰ It is now well accepted that a fully informed patient who has decision-making capacity, has the right to refuse any life-sustaining medical treatment, notwithstanding that death may result. This right is grounded in the importance of respecting a patient's autonomy and self-determination in health care decisions, including decisions concerning the manner and timing of death.²¹ Proponents argue that if the law recognises the patient's autonomy and

¹⁶ See, for example, Williams, *The Sanctity of Life and the Criminal Law*, 277-312 and the analysis of Williams' argument by Richards, 335-336. See also Young, 279-282.

¹⁷ Richards, 335-401; Rachels, 154-158; S. Brooks, 'Dignity and Cost Effectiveness: A Rejection of the Utilitarian Approach to Death' (1984) 19 *J. Med. Ethics* 148; Y. Kamisar, 'Some Non-Religious Views Against Proposed Mercy-Killing Legislation' (1958) 42 *Minn.L.Rev.* 969, 1014-1041 where he also identifies this weakness in Williams' utilitarian arguments.

¹⁸ Richards, 401; Brooks, 148. Some philosophers have attempted to overcome these objections by arguing for the acceptance of rule-utilitarianism rather than act-utilitarianism (for discussion see J. Hospers, *An Introduction to Philosophical Analysis* (1967) 604-612) or by substituting calculations based on happiness with consideration of interests; see Rachels, 156-158.

¹⁹ H. Kuhse, 'Euthanasia - Again' (1985) 142 *M.J.A.* 610; P. Nowell-Smith, 'Death by Request as a Right' (1987) 2 *Euthanasia Rev.* 80, 93; S. Wolhandler, 'Voluntary Euthanasia for the Terminally Ill and the Constitutional Right to Privacy' (1984) 69 *Cornell L.Rev.* 363, 369; P. Small, 'Euthanasia - the Individual's Right to Freedom of Choice' (1970) 5 *Suffolk U.L.Rev.* 190; R. Richter, 'The Hastings Center and Euthanasia' (1988) 3 *Euthanasia Rev.* 56.

²⁰ See chapter II, 33-37.

²¹ Hastings Center Report, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (1987) 128 (hereafter referred to as the Hastings Center Report); President's Commission for

self-determination as justification for passive euthanasia, it is logically inconsistent to refuse to recognise the same interests as a justification for active euthanasia.²² This argument, based on the inconsistency of the present law, derives significant support from the claim by many philosophers and ethicists that there is no morally relevant difference between passive euthanasia - deliberately letting a patient die - and active euthanasia- the killing of a patient; both involve the intentional termination of life.²³ Moreover, it is argued that to deny active assistance to a patient who seeks it, is not only an infringement of that person's interest in self-determination, but may also be contrary to the patient's 'best interests', since the alternative of letting die may be neither swift nor painless.²⁴ Furthermore, since not all terminal or incurable patients are dependent on life-sustaining treatment they do not all have the option of inducing death by refusing treatment, except perhaps by slowly starving and dehydrating themselves to death. It could, therefore, be argued that the present law is discriminatory in its operation since it does not offer to all patients the same opportunity of inducing an earlier death.

Whilst many commentators support the view that there is no morally relevant difference between active and passive euthanasia, others have argued for the retention of the distinction. Some commentators have sought to defend the validity of the distinction on moral grounds arguing that there *is* a morally relevant difference between active and passive euthanasia which justifies maintenance of the prohibition against active euthanasia or 'killing'.²⁵ Others have argued that irrespective of philosophical arguments, a distinction is discernible in practice in view of the willingness of doctors to allow patients to die, contrasted with their intuitive opposition to active voluntary euthanasia.²⁶ This claim can, however, be quickly countered on the basis that it purports to treat a value judgment as evidence and, furthermore, suggests that there is unanimity within the medical profession on the issue of active euthanasia which is clearly not the case.²⁷ What this alleged

the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 72. (Cited hereafter as the President's Commission Report.)

22 For example, H. Kuhse, 'The Case for Active Voluntary Euthanasia' (1986) 14 *Law, Med. & Health Care* 145.

23 There is a growing body of literature on the moral significance of the killing/letting die distinction, much of which was spawned by the argument presented by J. Rachels, in his article 'Active and Passive Euthanasia' (1975) 292 *New Eng.J.Med.* 78 which challenged the conventional doctrine that there is an important moral difference between killing and letting die. For other commentators in support of the moral equivalence view see H. Kuhse, *The Sanctity of Life Doctrine in Medicine* (1987) 123-135; Singer, 147-153; Fletcher, 'Ethics and Euthanasia', 675; J. Ladd, 'Positive and Negative Euthanasia' in J. Ladd, (ed.) *Ethical Issues Relating to Life and Death* (1979) 164-186.

24 Kuhse, 'Active and Passive Euthanasia - Ten Years into the Debate', 117; Singer, 152-153; M. Battin, 'The Least Worst Death' (1983) 13 *Hastings Center R.* 13, 13-14; P. Admiraal, 'Justifiable Euthanasia' (1988) 3 *Issues Law & Med.* 361, 368-370.

25 For example, E. Keyserlingk, *Sanctity of Life or Quality of Life*, Law Reform Commission of Canada (1979) 123-126; T. Beauchamp, 'A Reply to Rachels on Active and Passive Euthanasia' in T. Beauchamp and S. Perlin, (eds.) *Ethical Issues in Death and Dying* (1978) 246-258; R. Veatch, *Death, Dying and the Biological Revolution* (1976) 80-93; R. McCormick, 'Notes on Moral Theology' (1976) 37 *Theological Studies* 100.

26 G. Gillett, 'Euthanasia, Letting Die and the Pause' (1988) 14 *J.Med. Ethics* 61. See also D. Maguire, *Death by Choice* (1984) 98 where he argues that omissions and commissions are different realities and since morality is based on reality a *real* difference could be expected to make a *moral* difference.

27 M. Parker, 'Moral Intuition, Good Deaths and Ordinary Medical Practitioners' (1990) 16 *J.Med. Ethics* 28, 29. For discussion of the views of the medical profession see chapter VI, 261-290.

distinction does, perhaps, reveal is that there is an element of self-deception operative here which may assist doctors in justifying their conduct in permitting patients to die.²⁸

There are others still, including the influential President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, in its Report *Deciding to Forgo Life-Sustaining Treatment*, who are prepared to acknowledge that the distinction between acts and omissions leading to death is not of itself morally relevant, yet nevertheless argue for maintenance of the current prohibition of active voluntary euthanasia on practical grounds.²⁹ For example, concern is frequently expressed about the irrevocability of active euthanasia, allowing no opportunity for a change of mind or to correct mistakes, but the most serious concerns stem from a fear of abuse and other negative social consequences if active voluntary euthanasia was legalised.³⁰ A rebuttal of these practical arguments will be presented later in this chapter.³¹

There is no doubt at all that the existing prohibition on active voluntary euthanasia places significant limits on the self-determination of some patients. This has been recognised by many of those resisting legalisation yet has not been seen as sufficient justification for any change to the present law. A prime example of this approach is to be found in the Report of the President's Commission. The commission acknowledged that policies prohibiting direct killing may conflict with the important value of patient self-determination but nonetheless went on to find this limitation on individual self-determination to be an acceptable cost of securing the general protection of human life.³²

This reasoning is open to criticism. Particularly if one accepts the force of the argument that there is no intrinsic moral difference between active and passive euthanasia, there appears to be no valid justification for refusing to uphold the patient's self-determination in cases of active voluntary euthanasia. The practical arguments against the legalisation of active voluntary euthanasia (e.g. the possibility of error and abuse) can be adequately addressed through the introduction of appropriate regulations and safeguards and do not justify undermining the patient's right of self-determination. The only acceptable limitation on the patient's right to make decisions for him or herself is the requirement that the patient has decision-making capacity and is in a position to make an informed choice.

²⁸ G. Robertson, 'Dealing with the Brain Damaged Old - Dignity Before Sanctity' (1982) 8 *J. Med. Ethics* 173, 174. See also E. Bates, 'Decision Making in Critical Illness' (1979) 15 *A. & N.Z.J. of Sociology* 45, 47 where, in a survey of medical practitioners, many of the doctors are reported to have seized upon the distinction between active euthanasia and the cessation of treatment.

²⁹ The President's Commission Report, 65-73; N. Cantor, 'A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life' (1973) 26 *Rutgers L.Rev.* 228, 260-262; A. Capron, 'The Right to Die: Progress and Peril' (1987) 2 *Euthanasia Rev.* 42, 53-59.

³⁰ See below, 202-206.

³¹ See below, 201-221.

³² The President's Commission Report, 73; the Hastings Center Report, 129. For criticism of these reports see Kuhse, 'Active and Passive Euthanasia - Ten Years into the Debate', 117-118; and Richter, 56-71 respectively.

Analogy with Suicide

Another argument frequently advanced in support of legalisation of active voluntary euthanasia proceeds by way of analogy to the law of suicide. The argument begins with the proposition that since it is not unlawful for a person to commit or attempt to commit suicide,³³ the law, implicitly at least, recognises the right of an individual to take his or her life. From this premise it is argued that if an individual does have the right to take his or her life he or she should be able to seek the assistance of others in achieving this end.³⁴

A Right to Commit Suicide?

Some commentators have argued for a moral right to commit suicide, at least in some circumstances.³⁵ The real issue, however, for the purposes of the present discussion, is whether an individual has a *legal right* to commit suicide. The answer to this question must be in the negative, particularly in view of the continuing prohibition on assisting suicide and the laws which uphold intervention in the suicide of another.³⁶ The most accurate assessment of the current position is that the decriminalisation of suicide and attempted suicide has not created any positive or legally enforceable *right* to commit suicide - it has merely given persons the *liberty* of choosing to end their own lives without thereby incurring criminal liability.³⁷ It could, nevertheless, still be argued that if persons are at liberty to commit suicide, they should also be free to seek the assistance of others in achieving their aim and, if necessary, to authorise another to take active steps to bring about their death.³⁸ Further to this argument, if a third person complies with a request for assistance they ought not be penalised since they are simply facilitating what the individual is at liberty to do. It must be emphasised that this argument does not necessarily entail general endorsement of suicide and suicide assistance. In many instances, suicidal persons are psychologically disturbed and should be prevented from implementing their plan.³⁹ There are, however, cases where the choice of death is rational and where it would be entirely inappropriate to intervene, for example, in circumstances where a terminal or incurable patient seeks death as a relief from his or her suffering.

³³ For a discussion of the law dealing with suicide and attempted suicide, see chapter III, 83-87.

³⁴ J. Rachels, 'Barney Clark's Key' (1983) 13 *Hastings Center R.* 17, 19; Fletcher, 'The Courts and Euthanasia' (1987-88) 15 *Law, Med. & Health Care* 223, 228; H. Pohlmeier, 'Suicide and Euthanasia - Special Types of Partner Relationships' (1985) 15 *Suicide & Life Threatening Behaviour* 117, 119.

³⁵ For example, M. Battin, 'Suicide: A Fundamental Human Right?' in M. Battin and D. Mayo, (eds.) *Suicide* (1980) 267-285; and M. Charlesworth, *Life, Death, Genes and Ethics* (1989) 70-71. For commentators arguing against the morality of suicide, see, for example, G. Grisez, 'Suicide and Euthanasia' in D. Horan and D. Mall, (eds.) *Death Dying and Euthanasia* (1980) 742-817.

³⁶ See chapter III, 83-84, 100.

³⁷ See also H. Trowell, *The Unfinished Debate on Euthanasia* (1973) 120-121. It should be noted that some commentators have suggested that in the United States a right to commit suicide should be recognised by virtue of the United States Constitution; e.g. S. O'Brien, 'Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle Into That Good Night' (1987) 31 *St. Louis U.L.J.* 651, 656, 666-671; Richards, 403-407. *Contra* T. Marzen *et al.*, 'Suicide: A Constitutional Right?' (1985) 24 *Duq.L.Rev.* 1.

³⁸ Some commentators have, however, drawn attention to the differences between active voluntary euthanasia and assisted suicide; see, for example, R. Weir, 'The Morality of Physician-Assisted Suicide' (1992) 20 *Law, Med & Health Care* 116, 118-119.

³⁹ A. Browne, 'Assisted Suicide and Active Voluntary Euthanasia' (1989) 2 *Can.J.L.Juris.* 35, 39.

Significance of Third Party Involvement

On the assumption that there is some validity in the analogy between suicide and active voluntary euthanasia, a crucial question which needs to be addressed is what significance, if any, should be attached to the fact that active voluntary euthanasia involves the direct assistance of a third party. Some commentators have argued that an important distinction exists between suicide on the one hand, which is an autonomous and self-regarding act, and assisted suicide or active voluntary euthanasia on the other, which requires the involvement and assistance of a third party.⁴⁰ This third party involvement, they argue, constitutes a crucial difference because the conduct changes from being a purely private act to a form of public action with ramifications extending beyond the parties involved.⁴¹ Moreover, it has been suggested that if the argument for active voluntary euthanasia is based on dignity of human freedom and self-determination, then it is inconsistent to ask someone else to assist.⁴² However, this objection ignores the practical realities of patients *in extremis* who are often physically unable to secure the means to a quick and easy death and may even be unable to self-administer the fatal dose if it were made available to them. Furthermore, on humanitarian grounds, it could be argued that it would be more compassionate and humane to assist those who wish to die but who are unable to kill themselves, or those who desire assistance, to ensure that death is assured and achieved in a dignified manner.

Whilst it is conceded that the involvement of third parties in cases of assisted suicide and active voluntary euthanasia does differentiate these cases from autonomous suicide, it is disputed that this significantly alters the character of the acts to such a degree that they should necessarily be prohibited. The more relevant consideration is whether the patient has requested active euthanasia. If the choice of death represents an exercise in patient autonomy and self-determination, this choice ought to be respected and it should be permissible to assist the patient in achieving his or her aim. The debate regarding third party involvement does, however, draw attention to the need to also respect the autonomy of others in dealing with a patient who seeks death.

Autonomy of Others

According to accepted principles of autonomy and liberty, individuals should be free to pursue their own life choices, provided that this does not violate the rights of any third parties. In promoting the self-determination and autonomy of the patient care must be taken not to interfere with the autonomy of others. In particular, doctors should not be required to abdicate their autonomy in favour of that of the patient. The position of third parties, and their right to remain clear of involvement in the practice of active euthanasia, can be ensured by the introduction of appropriate legislation specifying that

⁴⁰ Callahan, 4; W. Uren, 'On the Meaning of Life', paper delivered at Calvary Hospital Hobart, Bioethics Seminar, 'On the Meaning of Life' 22 Oct. (1988) 16-17.

⁴¹ *Ibid.*

⁴² Linacre Centre, Report of a Working Party, *Euthanasia and Clinical Practice* (1982) 28-29.

doctors are under no *duty* to perform active euthanasia at the request of a patient, but may, in appropriate circumstances, be free to do so if they choose.⁴³

A Right to Die?

Any attempt to analyse whether there is a 'right to die', or whether such a right should exist encounters enormous difficulties. To begin with, the popular notion of a 'right to die' is virtually meaningless in view of the fact that ultimately, death is inevitable for everyone. Moreover, the right to die is ambiguous in that it can mean anything from a right not to be kept alive against one's will or a more positive right to seek assistance to die.⁴⁴ For the purposes of the present discussion, it will be assumed that the expression 'right to die' is intended to convey a right to active assistance in bringing about one's death. Understood in this way, it can be categorically stated that there is at present no legal 'right to die'.⁴⁵ Moreover, on the basis of current human rights instruments, there is no positive human 'right to die' and it is generally accepted that such a right cannot properly be inferred from the existence of a 'right to life'.⁴⁶

If one accepts the principle of self-determination as the basis for active voluntary euthanasia, it remains to be determined what legal status should be given to the patient's interest in choosing an earlier death. In particular, it must be decided whether patients should have a 'right to die', either expressed in terms of a basic human right⁴⁷ or even a legal right.⁴⁸ Apart from problems of definition, there are serious difficulties in adopting a strict rights-based model as the basis for legalisation of active voluntary euthanasia. Although the notion of 'rights' is expansive and, in its wider sense, can be used to encompass a variety of legal concepts,⁴⁹ strictly speaking, rights (as distinct from liberties or privileges) are correlative with duties. Thus, the creation of any *right* to active euthanasia implies a corresponding *duty* on the part of someone to become actively involved in

⁴³ But see the view of Grisez and Boyle, 163 where it is argued that the legalisation of active voluntary euthanasia would infringe on the liberty of citizens to stand aloof from the practice regardless of whether they are personally involved in its administration.

⁴⁴ *Ibid.* See also the Parliament of Victoria Social Development Committee, Second and Final Report *Inquiry into Options for Dying with Dignity* (1987) 96, 138-139 for acknowledgment of the difficulties involved in interpreting a 'right to die'.

⁴⁵ The position in the United States requires special consideration in light of the attempts by some commentators to argue that the constitutional right of privacy should encompass determination of the manner and timing of one's own death; e.g. R. Delgado, 'Euthanasia Reconsidered - the Choice of Death as an Aspect of the Right of Privacy' (1975) 17 *Ariz.L.Rev.* 474; Wolhandler. However, in light of recent case-law developments in the United States it is extremely unlikely that the United States Supreme Court would extend the constitutional right of privacy to encompass a patient's right to die. (See chapter II, 47-48.)

⁴⁶ Bailey, 9-10, 267-268. Article 6 (para. 1) of the *International Covenant on Civil and Political Rights* which Australia has ratified provides that: 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.'

⁴⁷ For example, R. Russell, *Freedom to Die* (Revised ed., 1977) 232; R. Mitchell, 'Euthanasia: A Human Right?', paper delivered to the ANZAAS Symposium, 'Modern Technology and the Right to Die' (1985) No. 276; C. Hadding, 'Right to Die - a Corollary to the Right to Live and the Right to Leave' (1989) 7 *Med. Law* 511.

⁴⁸ Arras, 293-294. It should be noted that not all human rights are necessarily legal rights; see P. Bailey, *Human Rights* (1990) 5.

⁴⁹ W. Hohfeld, *Fundamental Legal Conceptions* (1919) 6-7, 36-38.

the inducement of death.⁵⁰ There is broad agreement amongst euthanasia advocates that it would be inappropriate to impose a duty on any person to take the life of another. Although such a duty would uphold the autonomy of the patient who requests assistance, it is recognised that it would be an unjustifiable interference with the autonomy of others. It is primarily to avoid the implication of any such duty and the resulting infringement of the autonomy of third parties that the rights-based model has been widely rejected as an appropriate basis for the legalisation of active voluntary euthanasia.⁵¹

Self-Determination and the Liberty to Choose an Earlier Death

The dilemma which confronts us is to find some way to give effect to the autonomy and self-determination of the patient, but, at the same time, to protect the autonomy of others. This dilemma can best be resolved by holding that the patient's right of self-determination does not necessarily translate into an enforceable legal *right* to demand assistance to die. The patient's interest in self-determination can be appropriately protected by recognising a *liberty*⁵² to choose an earlier death and having the assistance of a doctor in bringing it about. If the patient's interest is expressed in terms of a liberty rather than a legal right it would not be enforceable by the courts and would not create any duties upon others to accede to a patient's request for death.⁵³ Thus, a doctor willing to assist would be *permitted* to perform active euthanasia at the request of a patient without being under any duty to do so. The creation of a liberty would nevertheless be significant in that persons desiring active voluntary euthanasia would not be restrained from exercising that choice, and provided they have a doctor willing to comply with their request, they may lawfully secure a quick and painless death. Indeed, the mere knowledge that active voluntary euthanasia is available in the event that suffering becomes unbearable would in many instances be sufficient to put patients in control and remove the fear of having to endure intolerable pain or other distress.⁵⁴

It is clear from the foregoing analysis that the principle of self-determination is central to the case for legalisation of active voluntary euthanasia. Consideration will now turn to a number of other arguments which support the case for legalisation.

⁵⁰ For example, T. Campbell, 'Euthanasia and the Law' (1979) 17 *Alta L.Rev.* 188, 189; S. Potts, 'Looking for the Exit Door: Killing and Caring in Modern Medicine' (1988) 25 *Hous.L.Rev.* 493, 509; P. Williams 'Rights and the Alleged Rights of Innocents to be Killed' (1976-77) 87 *Ethics* 383, 384.

⁵¹ For example, P. Williams; F. Maher, 'Euthanasia' (1985) 59 *Law Inst.J.* 445; Trowell, 116-121.

⁵² For a definition of a 'liberty', see, for example, Grisez and Boyle, 453 (defined as the absence of imposed constraints to pursuing one's own purposes in one's own way); J. Feinberg, *The Moral Limits of the Criminal Law* Vol. I *Harm to Others* (1984) 7 (the absence of legal coercion).

⁵³ See Trowell, 120-121; Hohfeld, 7, 38-50.

⁵⁴ This proposition is supported by the findings of the Remmlink study in the Netherlands; see chapter VIII, 382-383, 392.

Prevention of Cruelty: An Argument from Mercy

Another argument, which is a cornerstone of the case for the legalisation of active voluntary euthanasia, is the need to alleviate pain and suffering and to prevent cruelty.⁵⁵ Proponents argue that to maintain the legal prohibition on active voluntary euthanasia amounts to cruel and degrading treatment and that cruelty is an evil which must be avoided so far as possible. They argue that in circumstances where there is no reasonable prospect of meaningful recovery, considerations of commonsense and compassion demand that patients should be allowed a merciful release from prolonged and useless suffering. Further, as noted earlier, reliance on the passive form of euthanasia will not necessarily guarantee a swift and painfree death. If, however, active voluntary euthanasia were legalised, doctors would be able to comply with a patients' request to die and the merciful and kindly treatment of patients would be promoted.

A potential conflict exists between the duty to prevent cruelty and relieve suffering, and the doctor's duty to save life. This conflict can best be resolved by holding that where a patient has voluntarily requested active euthanasia, the greater duty is to accede to the patient's request and avoid unnecessary suffering.⁵⁶ Although legalising active voluntary euthanasia would not totally eliminate all pain and suffering associated with terminal illness, it would significantly reduce the burden on patients by placing the power to end a miserable existence under the patient's own control.⁵⁷ This empowerment of the individual may in turn improve the quality of the remaining time, and may in fact assist the patient to live longer, confident in the knowledge that assistance is available if needed.

The argument from prevention of suffering and cruelty has been more positively stated by Kohl who has advocated the principle of 'beneficent euthanasia'.⁵⁸ Kohl argues that active euthanasia is 'kind' treatment and since society and its members have a *prima facie* obligation to treat members kindly, it follows that beneficent euthanasia is a *prima facie* obligation.⁵⁹ The value of Kohl's contribution to the debate has been to highlight that active euthanasia is a means of minimising suffering and maximising kind and loving treatment of patients. However, for the reasons outlined above,⁶⁰ the notion of a *prima facie* obligation to provide euthanasia must be rejected, at least in so far as it implies that a *duty* is cast upon any particular individual to perform an act of euthanasia.

⁵⁵ For example, G. Williams, 'Euthanasia Legislation: A Rejoinder to the Non-Religious Objections', in A. Downing and B. Smoker, (eds.) *Voluntary Euthanasia* (1986) 156, 156-157; Morris, 254; A. Flew, 'The Principle of Euthanasia' in Downing and Smoker, 40, 43; H. Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands' (1989) 8 *Med. Law* 517, 518; Rachels, *The End of Life*, 152-154.

⁵⁶ More detailed consideration of the role of the doctor is presented below, 217-220.

⁵⁷ Morris, 254.

⁵⁸ See M. Kohl, *The Morality of Killing* (1974) 106 where he sets out the conditions for beneficent euthanasia; the act must involve a painless inducement of a quick death, the act must result in beneficial treatment for the recipient, the act is intended to be helpful and is done so that if there is any expectation of receiving remuneration (or the like), the individual would still act in that manner, even if it becomes apparent that there is little or no chance of his expectation being realised.

⁵⁹ *The Morality of Killing*, 96, 106; 'Voluntary Beneficent Euthanasia', in Kohl, *Beneficent Euthanasia* 130, 135.

⁶⁰ See above, 186-187.

Opponents of euthanasia have sought to undermine these arguments based upon the prevention of cruelty and need for merciful treatment by suggesting that the concepts of 'mercy' and 'prevention of cruelty' are flexible, capable of differing interpretations, and that this may, with time, result in an ever increasing category of candidates for active euthanasia.⁶¹ Further, it is claimed that the concern of proponents is often not with the pain and suffering of the patient but of the family, relatives and friends who must witness the patient's last days.⁶² However, these arguments ignore the fact that what is being considered here is *voluntary* euthanasia, firmly based on the fundamental principle of self-determination. The crucial issue is not whether the doctors believe it would be merciful to terminate life, or the need to relieve the understandable anguish of loved ones, but whether the patient seeks active euthanasia as a release from his or her suffering.

Promotion of Human Dignity

Closely related to the foregoing arguments based on self-determination and the prevention of cruelty is the argument that legalisation of active voluntary euthanasia is necessary in order to promote human dignity. Proponents argue that the notion of human dignity demands that individuals have control over significant life decisions, including the choice to die, and that this control is acknowledged and respected by others.⁶³ This argument is well encapsulated by Fletcher where he states that 'to prolong life uselessly, while the personal qualities of freedom, knowledge, self-possession and control, and responsibility are sacrificed, is to attack the moral status of a person'.⁶⁴

Advances in medical technology have greatly increased the capacity of the medical profession to prolong life. In many cases, however, death can be merely forestalled and patients may face the prospect of a prolonged and agonising death. For many patients, the principal fear is not of pain or even death itself, but of loss of control of bodily and mental functions and the resulting helplessness and dependence on others - in short the depersonalisation of the dying. Patients may understandably wish to spare themselves and their loved ones the indignity of a prolonged death and creeping mental and physical deterioration. Indeed, it is this concern for the circumstances of one's dying that has largely fuelled the campaign for 'death with dignity'.⁶⁵

The present law permits passive euthanasia, but this will not guarantee a patient a humane and dignified death. On the contrary, a 'natural death' achieved by the refusal of treatment may be

⁶¹ For example, A. Dyck, 'The Good Samaritan Ideal and Beneficent Euthanasia: Conflicting Views of Mercy' (1975) 42 *Linacre Q.* 176, 180-181.

⁶² For example, G. Parker, 'You are a Child of the Universe: You Have a Right to be Here' (1977) 7 *Man.L.J.* 151, 155. For consideration of some of the other arguments of opponents regarding the issue of prevention of cruelty and suffering, see E. Kluge, *The Ethics of Deliberate Death* (1981) 39-42.

⁶³ For example, M. Moore, 'The Case for Voluntary Euthanasia' (1974) 42 *U.M.K.C.L.Rev.* 327, 332; Browne, 38; Morris, 251-255.

⁶⁴ *Morals and Medicine*, 191.

⁶⁵ For discussion of legislative developments with regard to 'dying with dignity' see chapter VII.

particularly unpleasant and undignified.⁶⁶ Preservation of human dignity can only be assured with the acceptance of active voluntary euthanasia, and the recognition of the liberty of the individual to determine the manner and timing of his or her death.

Opponents of euthanasia have challenged this reasoning on two fronts. First, they claim that *all* individuals have intrinsic worth and dignity and it would therefore be immoral to sanction the death of any individual. Indeed, they argue, it is because of their respect for human worth and dignity that they steadfastly disapprove of active voluntary euthanasia.⁶⁷ Second, they assert that the argument based on the notion of human dignity logically entails that all who live in an unalterably undignified form of existence ought to be killed.⁶⁸ Both of these arguments are misconceived. The first argument is flawed because it proceeds on a different notion of 'dignity' than that which is being claimed here, namely the power to control important aspects of one's life including matters of life and death. Acceptance and preservation of human dignity in this sense in no way purports to deny the intrinsic worth and dignity of all human beings regardless of their health or condition.⁶⁹ The second argument, reminiscent of the objections raised against the prevention of cruelty argument, also fails because it ignores the important correlation between preserving human dignity and upholding the patient's interest in self-determination. If self-determination is accepted as the touchstone, there can be no suggestion that persons will be disposed of, on the basis of some objective assessment of whether their life lacks dignity.

What is Morally Right Should be Made Legally Permissible

Another argument advanced by some proponents, is that since active voluntary euthanasia is acknowledged by many to be *morally* right, it should be made *legally* permissible.⁷⁰ In furtherance of this argument, attention is drawn to the conflicting demands placed on individual doctors faced with a request for active euthanasia; on the one hand, the desire to act mercifully and relieve the patient's suffering and on the other, the concern to be a law-abiding citizen and avoid violation of the criminal law. Proponents argue that this places doctors in an intolerable situation and that society has a duty to make legally permissible conduct that is merciful and widely recognised as morally right.⁷¹

It is certainly true that notwithstanding the forceful objections of some commentators, there has been widespread support from a variety of sources for the view that in certain circumstances, active

⁶⁶ For example, Battin, 'The Least Worst Death', 13-14; Admiraal, 368-370.

⁶⁷ For example, British Medical Association (B.M.A.) Working Party Report, *Euthanasia* (1988) 40; L. Gormally, 'A Non-Utilitarian Case Against Voluntary Euthanasia', in Downing and Smoker, 72, 82-88.

⁶⁸ See E. Kluge, *The Practice of Death* (1975) 154-157 for an analysis of this argument. A number of commentators have also drawn attention to the variable understandings of dignity; see Dyck, 180-181; Kluge, *The Ethics of Deliberate Death*, 42-44.

⁶⁹ Kohl, 'Voluntary Beneficent Euthanasia', 132-134 where he examines the different interpretations of 'dignity'.

⁷⁰ For example, Russell, 235-236; G. Williams, 'Euthanasia and Abortion' (1966) 38 *U.Colo.L.Rev.* 178, 182.

⁷¹ Russell, 235.

voluntary euthanasia is morally justified.⁷² Subject to possible negative consequences which may flow from the legalisation of active voluntary euthanasia, which will be dealt with below,⁷³ a strong argument can be made that the law should reflect prevailing morality. This argument will be developed later in this chapter in the part dealing with the role of the criminal law.⁷⁴ It should be noted, however, that the arguments in this thesis do not necessarily depend on the acceptance of the morality of active voluntary euthanasia.

One possible counter-argument which will be dealt with more fully in the context of the case against legalisation is that an important distinction exists between the morality of the individual case and the appropriateness of developing a public policy permitting active voluntary euthanasia.⁷⁵ In fact, many opponents of legalisation are prepared to concede the morality of active voluntary euthanasia in exceptional circumstances, but vigorously reject the introduction of legislation to cover such cases. The validity of this position in turn depends on an assessment of the practical objections to the legalisation of active voluntary euthanasia which will be undertaken later in this chapter.⁷⁶

Formalise Current Practices

A further argument in support of the legalisation of active voluntary euthanasia is that we need to formalise existing practices. There are two separate aspects of this argument: first, the argument that since the practice of active euthanasia already occurs, we need to institutionalise and regulate the practice with the adoption of proper safeguards in order to protect against the risk of abuse; and second, that the practice should be legalised to overcome existing discrepancies between legal theory and practice. Both of these arguments will now be considered in turn.

The Need to Regulate and Protect Against Abuse

Reference was earlier made to available evidence which indicates that some doctors, at least, are already involved in the practice of active voluntary euthanasia even though this contravenes the criminal law.⁷⁷ As many of the opponents of legalisation have pointed out, the mere fact that the law is being broken is not of itself a valid ground for legal change.⁷⁸ There are, however, certain difficulties inherent in the present situation which call for a re-evaluation of the prohibition of active voluntary euthanasia. Because the practice is presently illegal, it is performed secretly without any opportunity for consultation or regulation. Particularly in light of the paternalistic nature of the

⁷² Support has come from theologians; e.g. J. Fletcher, (Episcopal Minister), D. Maguire, (Catholic philosopher); lawyers (e.g. G. Williams); doctors (e.g. R. Syme and M. Parker); and ethicists and philosophers (e.g. M. Kohl and R. Young).

⁷³ See below, 201-221.

⁷⁴ See below, 222-228.

⁷⁵ For example, Hamel, R. (ed.) *Active Euthanasia, Religion and the Public Debate* (1991) 93-109.

⁷⁶ See below, 201-221.

⁷⁷ See chapter IV, 117-121.

⁷⁸ For example, Grisez and Boyle, 146; C. Dessaur and C. Rutenfrans, 'The Present Day Practice of Euthanasia' (1988) 3 *Issues Law & Med.* 399, 405.

medical profession, this creates a very real risk that active euthanasia may be performed by a doctor on the basis of what he or she perceives to be the patient's best interests, but without the consent of the patient. This is clearly contrary to the fundamental principle of self-determination and the requirement of voluntariness in the practice of active euthanasia. Further, since some doctors may be more willing than others to contravene the criminal law, the option of active euthanasia is not presently available to all patients, thereby causing potential injustice to some.⁷⁹

The essence of the proponents' argument is that if the practice already occurs, it is preferable for it to be legalised and brought out into the open in order that appropriate safeguards can be implemented to protect against abuse.⁸⁰ There is good reason to believe that acts of non-voluntary euthanasia would be reduced if a form of active voluntary euthanasia was legally available and the need for secrecy was overcome. Legalisation of active voluntary euthanasia would promote open discussion of the issues and would thereby contribute to the quality of decision-making. Legalisation would also ensure that active voluntary euthanasia would be an option available to all patients subject only to the right of a doctor to decline to become involved in the practice. Patient self-determination would thereby be promoted.

The Need to Overcome Discrepancies between Legal Theory and Practice

The second part of the proponents' argument concerns the need to overcome existing discrepancies between legal theory and practice. Proponents point out that even though there is evidence to suggest that some doctors are engaged in the practice of active voluntary euthanasia which constitutes murder, if one has regard to the realities of the law in practice, it is unlikely that a doctor would be prosecuted, or if prosecuted, that he or she would be convicted. From this premise, they argue that the law in operation in effect condones the practice of active voluntary euthanasia. Proponents go on to assert that the present disparity between legal theory and the law as it operates in practice is unsatisfactory, encouraging cynicism and disrespect for the law.⁸¹ Further, it is argued, that whilst it is most unlikely that a doctor would be prosecuted and convicted, there is, nevertheless, no guarantee of this;⁸² indeed the very informality of the present situation invites arbitrary and capricious results. Moreover, it is argued to be unsatisfactory that doctors who are acting *bona fide* and at the request of the patient should be exposed to the risk of prosecution. Thus, proponents are of the view that active voluntary euthanasia ought to be legalised in order to close the gap between theory and practice, and to ensure that doctors who perform active voluntary euthanasia are not vulnerable to criminal prosecution.⁸³

⁷⁹ For example, D. Humphry, 'Euthanasia for the Elite' (1986) 1 *Euthanasia Rev.* 203; Institute of Medical Ethics, Working Party on the Ethics of Prolonging Life and Assisting Death, Discussion Paper 'Assisted Death' (1990) 336 *Lancet* 610, 611 (hereafter referred to as the Institute of Medical Ethics, Working Party Discussion Paper).

⁸⁰ A. Levisohn, 'Voluntary Mercy Deaths' (1961) 8 *J. Forensic Med.* 57, 69; Institute of Medical Ethics, Working Party Discussion Paper, 611.

⁸¹ See chapter IV, 146-150.

⁸² This has been demonstrated by the recent prosecution and conviction of Dr Cox in the United Kingdom for the attempted murder of his patient. For discussion see chapter IV, 126-127.

⁸³ For example, Levisohn, 69.

The problems which stem from the present disparity between law and practice are serious and constitute good cause to re-evaluate the present criminal law prohibition on active voluntary euthanasia. A strong case can be made out that legalisation of the practice is necessary in order to overcome these difficulties and to provide legal guidance for the making of medical and ethical decisions regarding the termination of life.

Arguments have also been advanced against legislating to overcome the present discrepancies between law and practice.⁸⁴ It has, for example, been argued that notwithstanding the occasional contravention of the law, the existing prohibition plays an important part in preventing many more cases of active euthanasia, a significant proportion of which would be non-voluntary and which would not in any event be legalised.⁸⁵ The validity of this argument depends in turn on the so-called 'wedge argument' which will be considered later in this chapter.⁸⁶ For present purposes, it can be stated that the legalisation of active voluntary euthanasia would not necessarily affect the incidence of cases of active non-voluntary euthanasia; active non-voluntary euthanasia is currently prohibited by the criminal law and would remain so.

Resource Considerations

Another argument in support of legalisation is based on economic considerations.⁸⁷ The essence of this argument is that to introduce a law enabling patients to seek active voluntary euthanasia would indirectly assist to ease the financial burden of health care for the patient, the patient's family and the community generally.

Reference has previously been made to the remarkable advances in medicine and medical technology in recent decades which have significantly extended the general life expectancy of the population and the capacity to prolong the life of dying patients.⁸⁸ There are, however, enormous financial costs involved in providing appropriate health care to the elderly and the chronically and terminally ill, and these costs are likely to increase in the future with the gradual ageing of the population.⁸⁹

⁸⁴ For an analysis of arguments against change of the law on grounds of discrepancy between theory and practice, see Grisez and Boyle, 148-149.

⁸⁵ For example, Grisez and Boyle, 148; Kamisar, 1042.

⁸⁶ See below, 202-205.

⁸⁷ See H. Hayry and M. Hayry, 'Euthanasia, Ethics and Economics' (1990) 4 *Bioethics* 154; A. Wickett, 'Health Care Costs and Euthanasia' (1986) 1 *Euthanasia Rev.* 158; J. Richardson, 'The Accountant as Triage Master: An Economist's Perspective on Voluntary Euthanasia and the Value of Life Debate' (1987) 1 *Bioethics* 226; H. Lander, 'Some Medical Aspects of Euthanasia' (1984) *M.J.A.* 173, 176; M. Battin, 'Age Rationing and the Just Distribution of Health Care: Is there a Duty to Die?' (1987) 97 *Ethics* 317.

⁸⁸ See the Introduction to this thesis, 1.

⁸⁹ E. Bates and H. Lapsley, *The Health Machine* (1985) 133; B. Pollard, *Euthanasia* (1989) 67-71; G. Alexander, 'Death by Directive' (1988) 28 *Santa Clara L. Rev.* 67, 70-74 (referring to the position in the United States.)

In 1986, 1.68 million people in Australia were aged 65 and over; 10.5% of the total population of 16 million. It is estimated that by the year 2005, 2.4 million people will be over 65; 11.9% of a total population of 20.2 million. By 2025 it is estimated that 3.8 million people will be over 65, 16.1% of a total population of 23.8 million. (the *Bulletin* April, 1988.) Health care expenditure by individuals

Notwithstanding growing demands, health care resources are finite, and difficult questions inevitably arise about their appropriate distribution. It is beyond the scope of this thesis to deal with the issue of equitable allocation of limited health care resources.⁹⁰ The one issue which does need to be addressed here is what economic advantages may accrue from the acceptance of a law which permits a doctor to act upon a patient's request for active euthanasia.

There is a natural reluctance of proponents to raise the resource dimension of the euthanasia debate, particularly because of the willingness of their opponents to unfairly manipulate such arguments to their own advantage. However, matters of costs and economics in health care cannot and should not be ignored.⁹¹ What must be emphasised is that economic considerations are of *secondary* importance to the fundamental principle of individual self-determination which lies at the heart of the proposed legalisation of active voluntary euthanasia. This is not to say that the financial implications of continued health care are irrelevant; in some instances, such considerations may influence the way in which patients exercise their right of self-determination, be it to refuse medical treatment or to seek active assistance in bringing about their death. But such considerations would never, on their own, be sufficient justification for the introduction of a policy of active euthanasia. The principle of self-determination demands that the individual decide the timing of his or her own death. Any suggestion that active euthanasia could be used as a means of cost containment in circumstances other than strictly *voluntary* euthanasia would be completely contrary to this principle and should therefore be categorically rejected.

Provided that it is clearly understood that active voluntary euthanasia is firmly based on the principle of self-determination, it is legitimate to recognise that legalisation would have certain advantages in preserving limited health care resources. Doctors would be able to satisfy the wishes of some patients by performing active voluntary euthanasia, and at the same time free up health care resources which can be made available to other patients who need and desire to have the maximum treatment available. It seems eminently sensible to ensure that health care resources are directed to where they are both wanted and required,⁹² and this is best achieved by not only respecting the patient's decision to refuse treatment, but to make active voluntary euthanasia an option available to all patients who have decision-making capacity.

and governments in Australia has increased in real terms approximately 25% from 1984-5 to 1990-1; Note, 'Australian Health Care Expenditure to 1990-1' (1992) 7 *Health Care Expenditure Bull.* 1-2.

⁹⁰ For consideration of this issue see, for example, D. Horvath, 'The Ethics of Resource Allocation' (1990) 153 *M.J.A.* 437; M. Somerville, 'Should the Grandparents Die?: Allocation of Medical Resources with an Aging Population' (1986) 14 *Law, Med. & Health Care* 158; Battin, 'Age Rationing and the Just Distribution of Health Care: Is there a Duty to Die?'; E. Pellegrino, 'Rationing Health Care: The Ethics of Medical Gatekeeping' (1986) 2 *J. Contemp. Health Law & Pol'y.* 23; R. Bayer, *et al.*, 'The Care of the Terminally Ill: Morality and Economics' (1983) 309 *New Eng. J. Med.* 1490; G. Smith, 'Death be Not Proud: Medical, Ethical and Legal Dilemmas in Resource Allocation' (1987) 3 *J. Contemp. Health L. & Pol'y.* 47; M. Mehlman, 'Rationing Expensive Life-Saving Treatments', (1985) 2 *Wis. L. Rev.* 239; H. Kuhse and P. Singer, 'Age and the Allocation of Medical Resources' (1988) 13 *J. Med. & Phil.* 101.

⁹¹ Hayry and Hayry, 155.

⁹² Alexander, 102-103; Battin, 'Age Rationing and the Just Distribution of Health Care: Is there a Duty to Die?', 336-340.

Public Demand and Support for Active Voluntary Euthanasia

The case for legalisation is further bolstered by evidence of growing public demand and support for active voluntary euthanasia. Public opinion polls have been periodically conducted in Australia, the United Kingdom, the United States and Canada to gauge public attitudes to whether active voluntary euthanasia ought to be legalised, and the results of these polls indicate increasing public support for its legalisation.⁹³

Opponents have been quick to challenge the relevance of such polls. At one level, they are critical of the manner in which the polls are conducted, particularly the way in which questions are framed.⁹⁴ More fundamentally, however, some opponents have challenged the relevance of opinion polls in shaping law and public policy, arguing that it is not necessarily appropriate to base the law on the opinion of the majority.⁹⁵ There is, they argue, no guarantee that the opinions polled are based on an informed understanding of the issues, and even if opinions are informed and valid, opponents question whether the moral worth of an argument is to be judged by the number of those who subscribe to it.⁹⁶

Apart from the opinion polls, further evidence of public support and demand for legalisation of active voluntary euthanasia is to be found in the emergence and growth in all jurisdictions of voluntary euthanasia societies actively campaigning for reform of the law in this area.⁹⁷ Moreover, the issue of active voluntary euthanasia has increasingly been brought before the public by the media, and the community response has generally been favourable.⁹⁸

Whilst it is, admittedly, very difficult accurately to assess the state of public opinion, available evidence regarding opinion polls and the growth of the voluntary euthanasia movement would appear to indicate that there is significant and increasing public demand and support for legalisation of active voluntary euthanasia. Since the role of the law is, at least in part, to meet the real needs of the community, evidence of public demand and support for legalisation of active voluntary euthanasia can only operate to strengthen the case for reform. More detailed consideration will be given to the relevance of public opinion and the role of the law later in this chapter.⁹⁹

⁹³ S. Waller, 'Trends in Public Acceptance of Euthanasia Worldwide' (1986) 1 *Euthanasia Rev.* 33. For further discussion see chapter VI, 229-239.

⁹⁴ For example, B.M.A. Working Party Report, *Euthanasia*, 41-42; Pollard, *Euthanasia* 59-62; Pollard, 'Killing the Dying - Not the Easy Way Out' (1988) 149 *M.J.A.* 312, 314; E. Keyserlingk, 'Public Opinion on Legalizing Active Euthanasia' (1987) 3 *Humane Med.* 139, 139.

⁹⁵ For example, B.M.A. Working Party Report, *Euthanasia*, 42.

⁹⁶ Pollard, *Euthanasia*, 62; B.M.A. Working Party Report, *Euthanasia*, 42.

⁹⁷ See chapter VI, 240-257.

⁹⁸ See chapter VI, 258-259.

⁹⁹ See below, 222-228.

The Case For Legalisation: An Evaluation

In the foregoing part, an attempt has been made to present and analyse the various arguments that have been raised in support of the legalisation of active voluntary euthanasia. It has been demonstrated that a number of powerful and convincing arguments can be raised in support of such legalisation, the most important of which is undoubtedly the libertarian principle of patient self-determination. On the strength of these arguments, taken together, a *prima facie* case exists for changing our laws to permit doctors to take active steps to end the lives of their patients at the patient's request.

An important aspect of the proponents' argument is that their claim for active voluntary euthanasia concerns a *liberty*; a claim to be free to seek assistance in determining the manner and timing of one's death. Proponents argue that in a free society, it is the *restraint* of liberty that must be justified, not the existence of liberty and that the criminal law should not be invoked to repress conduct unless this is demonstrably necessary on social grounds.¹⁰⁰ Thus, it is argued, the onus lies upon those objecting to the legalisation of active voluntary euthanasia to demonstrate why there should be restrictions on the liberty of the individual to seek and receive assistance in bringing about his or her death. In other words, opponents will have to convince proponents what compelling public interest demands that patients are denied a choice of a painfree and dignified death.¹⁰¹ If the opponents fail to discharge this onus, then we are left with compelling arguments for legalisation which ought to be acted upon.

Consideration must now turn to the case against legalisation of active voluntary euthanasia, to determine whether any of the objections raised by opponents are of sufficient force to justify the restraint of individual liberty and self-determination.

PART II

The Case Against Legalisation of Active Voluntary Euthanasia

The arguments advanced by the opponents can be divided into two categories; doctrinaire or deontological arguments on the one hand, and pragmatic or consequentialist objections on the other.¹⁰² Arguments falling into the first category are absolutist and theoretical in nature, whereas pragmatic or consequentialist arguments focus on the practical consequences of legalisation. According to the doctrinaire approach, active voluntary euthanasia is intrinsically wrong, regardless of the circumstances. Many of the religious and moral arguments fall within this category. This category also includes a number of moral and philosophical arguments against legalisation of active voluntary

¹⁰⁰ Williams, 'Euthanasia Legislation: A Rejoinder to the Non-Religious Objections', 157; Morris, 254-255; Flew, 40, 42; Moore, 330.

¹⁰¹ Browne, 40; Williams, 'Euthanasia Legislation: A Rejoinder to the Non-Religious Objections', 157.

¹⁰² Fletcher, 'The Courts and Euthanasia', 228.

euthanasia. Opponents of euthanasia adhering to this approach, the most notable of whom are Sullivan and Kelly, argue that in view of the inherent wrongfulness of active voluntary euthanasia, it should remain subject to unqualified prohibition.¹⁰³

However, a significant proportion of opponents are willing to concede that there are powerful arguments for the toleration of active voluntary euthanasia in individual cases, but contend that the institutionalisation of the practice is so fraught with risks and difficulties that it cannot be countenanced. Thus, the objection to active voluntary euthanasia is not necessarily based on the alleged wrongfulness of the individual act, but because of the undesirable consequences which it is feared may result if the practice is legalised.¹⁰⁴ These arguments are best characterised as pragmatic or consequentialist objections. It is proposed to deal with these different categories of objection in turn.

Doctrinaire Arguments Against Active Voluntary Euthanasia

Religious Arguments Against Active Voluntary Euthanasia

The following discussion will be focused on the Judaeo-Christian tradition which is the principal source of religious opposition to the practice of active voluntary euthanasia.¹⁰⁵ Notwithstanding some individual dissenters,¹⁰⁶ the Judaeo-Christian tradition has consistently condemned the practice of active voluntary euthanasia, and of all denominations, the Catholic Church has been most prominent in its opposition.¹⁰⁷

Sanctity of Human Life

Central to this opposition to active voluntary euthanasia is the fundamental belief in the sanctity of human life. Although no longer an exclusively religious concept,¹⁰⁸ the principle of sanctity of life clearly does have religious origins. Essentially, this principle holds that human life is sacred, having intrinsic value and must therefore be respected and preserved.¹⁰⁹ According to Christian tradition, life is a gift from God, and supreme dominion over life belongs to God alone.¹¹⁰ Human responsibility for life is one of 'stewardship'; man does not have absolute control over his own life, but merely holds

¹⁰³ J. Sullivan, *The Morality of Mercy Killing* (1950); G. Kelly, *Medico-Moral Problems* (1958) 115-116.

¹⁰⁴ For example, Kamisar, 975; Potts, 504-509; R. Weir, *Abating Treatment with Critically Ill Patients*, 417.

¹⁰⁵ For a discussion of other religious viewpoints regarding the practice of euthanasia, see G. Larue, *Euthanasia and Religion* (1985); D. Meyers, *Medico-Legal Implications of Death and Dying* (1981) 572-588.

¹⁰⁶ For example, Joseph Fletcher, an Episcopal minister, and Daniel Maguire, a Catholic philosopher, who have been prominent advocates for the legalisation of active voluntary euthanasia.

¹⁰⁷ The opposition of the Roman Catholic Church to euthanasia dates back to the time of St. Augustine. At various times in the history of the Catholic Church, official church pronouncements have condemned euthanasia; see Kelly, 115-118. Note also the Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980).

¹⁰⁸ J. Dedek, *Human Life* (1972) 12.

¹⁰⁹ The principle of sanctity of life is, however, not an absolute principle and is, therefore, distinguishable from 'vitalism' which holds that human life is an absolute value in itself and that every effort must be made to preserve life. See Keyserlingk, *Sanctity of Life or Quality of Life*, 30-35.

¹¹⁰ Meyers, 572-588.

it on trust for God. Only God, the Creator of life, has the right to decide at what moment a life shall cease, and any direct killing of the innocent without the authority of God is wrong and against the natural law.¹¹¹ The fact that the individual killed had given his or her consent does not alter the wrongfulness of the act. Similarly, suicide has always attracted religious sanction. Thus, man has the use of life, but may not destroy it at will, and to choose to do so involves a rejection of God's sovereignty.

The objection has been raised that if this 'divine monopoly theory' is carried through to its logical conclusion, it would mean that it is immoral to prolong life, since this is just as much an interference with God's sovereignty as is prematurely ending life.¹¹² However, according to Christian tradition, the prolongation of life by human intervention is justified on the grounds that it demonstrates respect for the value of human life, thereby confirming, rather than denying God's dominion.

Prohibition Against Intentional Killing

Closely related to the principle of God's sovereignty is the prohibition against killing contained in the Ten Commandments. The Sixth Commandment states 'thou shalt not kill' which would seemingly prohibit all intentional killing, even for merciful motives. It has, however, been argued that the interpretation 'thou shalt not kill' is an inaccurate translation from the original Hebrew and that a more precise translation would be 'thou shalt do no murder', i.e. unlawful killing.¹¹³ On this view, active euthanasia performed at the request of a patient would not be in contravention of the Sixth Commandment.

Furthermore, examination of the biblical prohibition against direct killing in its proper context reveals that it was never understood as an absolute prohibition on the taking of human life.¹¹⁴ Judaeo-Christian tradition has always recognised that in certain circumstances intentional killing may be permissible, for example, in the context of just war, capital punishment and legitimate self-defence.¹¹⁵ Thus, the biblical prohibition on killing is not an absolute principle but rather reflects the need to protect human life from arbitrary killing without community sanction. However, in the context of life and death decisions, the Commandment prohibiting killing has been understood as preventing the termination of human life, even for merciful reasons.¹¹⁶

The Value of Human Suffering

Another ground of religious objection to the practice of active voluntary euthanasia stems from the Christian belief in the value of human suffering. According to Christian teaching, physical suffering

¹¹¹ R. Gula, 'Euthanasia: A Catholic Perspective' (1987) 68 *Health Progress* 28, 29; Sullivan, 40.

¹¹² Fletcher, *Morals and Medicine*, 192-193; Magurie, 118-119; Rachels, *The End of Life*, 163-164.

¹¹³ Fletcher, *Morals and Medicine*, 196; Williams, *The Sanctity of Life and the Criminal Law*, 279; Rachels, *The End of Life*, 161-162.

¹¹⁴ Gula, 'Euthanasia: A Catholic Perspective,' 30.

¹¹⁵ Sullivan, 33-39; Fletcher, *Morals and Medicine*, 196.

¹¹⁶ For interpretation of the commandment under Roman Catholic teaching see, for example, the Linacre Center, Working Party Report, *Euthanasia and Clinical Practice*, 40-42. Compare with the position of the Anglican Church; Church Assembly Board for Social Responsibility, *On Dying Well* (1975) 23.

is not an absolute evil, devoid of purpose. Rather, it is seen as having a special place in God's divine plan for the universe, allowing an opportunity for the sufferer's spiritual growth and a means of redemption.¹¹⁷ Furthermore, those who are in contact with a suffering patient are given an opportunity to practice Christian charity.¹¹⁸ Thus, the practice of active voluntary euthanasia is rejected as a denial of the spiritual significance of suffering.

However, this objection to the practice of active voluntary euthanasia based on a belief in the value of human suffering has been subject to vigorous attack from a number of commentators.¹¹⁹ Williams points out that for anyone acquainted with the reality of suffering in illness, this argument must seem both absurd and intolerant.¹²⁰ Further, as Fletcher observes, if suffering were indeed part of God's divine plan which must, therefore, be accepted, we should not be able to give our moral approval to anaesthetics or to provide any medical relief of human suffering.¹²¹ This inconsistency regarding the place of suffering is itself reflected in Christian teaching; although the value of redemptive suffering is extolled, it is widely accepted that suffering can, in appropriate circumstances, be relieved, and the choice of whether or not to do so is a personal decision of conscience.¹²² However, active voluntary euthanasia as a means of relieving suffering is unequivocally rejected.

Status of Religious Objections to Euthanasia

It is evident from the foregoing review that religious opposition to the practice of active voluntary euthanasia is based on a number of interrelated arguments including adherence to the principle of the sanctity of life, the biblical prohibition against direct killing, and the value of human suffering. However, by their very nature, religious arguments based upon absolute adherence to faith are not really open to ethical reasoning or debate and may not accord with public opinion.¹²³ Consequently no attempt will be made to debate the merits of these religious arguments. Rather, it will be argued that religious objections are of limited practical relevance in determining whether the practice of active voluntary euthanasia should be legalised.

Religious arguments will naturally be convincing to those who accept the religious viewpoint but they clearly do not have universal relevance. Religion is a matter of personal commitment, and objections to active voluntary euthanasia based purely on religious views should not dominate the law nor impinge on the freedom of others. Whilst the convictions of believers must obviously be

¹¹⁷ Kluge, *The Ethics of Deliberate Death*, 32-33.

¹¹⁸ Sullivan, 47.

¹¹⁹ For example, Fletcher, *Morals and Medicine*, 196; Williams, 'Euthanasia and Abortion', 180; Maguire, 194; B. Smoker, 'A Rejoinder to Religious and Non-Consequentialist Objections to Euthanasia' in Downing and Smoker, 96, 99-100; Rachels, *The End of Life*, 164-165.

¹²⁰ Williams, 'Euthanasia and Abortion', 180.

¹²¹ Fletcher, *Morals and Medicine*, 196-198. See also Rachels, *The End of Life*, 165.

¹²² For a statement of the position of the Catholic Church, see the address of Pope Pious the XII, 'Religious and Moral Aspects of Pain Prevention in Medical Practice' (1957) 88 *Ir. Ecclesiastical Rec.* 193. Note also the Anglican position; Church Assembly Board for Social Responsibility, *On Dying Well*, 21, 39-50. This inconsistency argument can be taken further by reference to the Churches' approach to the withholding or withdrawing of treatment, particularly the position of the Catholic Church with regard to ordinary and extraordinary treatment. See chapter IV, 64-65.

¹²³ Fletcher, 'The Courts and Euthanasia', 228-229.

respected, it must be recognised that in a pluralistic and largely secular society, the freedom of conviction of non-believers must also be upheld.¹²⁴ It was stressed in the earlier part of this chapter that the main argument in the case for legalisation of active voluntary euthanasia is the principle of autonomy or self-determination.¹²⁵ Taking this principle into account, a powerful argument can be advanced to the effect that prohibitions on active voluntary euthanasia based purely on religious beliefs should not be applied by law to those who do not share that belief where this is not required for the welfare of society generally.¹²⁶ Only if the legal prohibition on active voluntary euthanasia is removed will everyone be able to live according to their own convictions; those who oppose active voluntary euthanasia could reject it for themselves, and those who are in favour of the practice are not forced to live against their convictions. It is entirely inappropriate for adherents to religious views to insist that their beliefs should be binding on all others.

Active Voluntary Euthanasia Inconsistent with the Inalienable Right to Life

Another doctrinaire argument against active voluntary euthanasia is that it is inconsistent with the inalienable right to life. According to this argument, derived from human rights philosophy,¹²⁷ individuals have certain inherent and inalienable rights including the right to life.¹²⁸ Consequently, active euthanasia performed at the request of a patient is *never* morally justifiable since it is a violation of this inalienable right. For strict adherents to a right to life philosophy, this argument would appear to be beyond controversy. The present criminal law which prevents a person from giving a legally effective consent to his or her own death can certainly be understood as supporting the view that individuals have an inalienable right to life.¹²⁹ However, some philosophers, including Feinberg, have persuasively argued that active voluntary euthanasia can be reconciled with the inalienable right to life.¹³⁰ Feinberg points out that if the opponents' argument regarding the impermissibility of active voluntary euthanasia is correct, it would effectively mean that the so called 'right to life' is in fact a mandatory right which entails a duty to live.¹³¹ This conclusion reveals the fallacy of the initial premise. It stands to reason that if something is a right at all then it must be capable of being given up. The right to life can be reconciled with acceptance of active voluntary euthanasia by recognising that although the right to life is inalienable, it can be *waived* in the exercise of one's discretion whether to continue to live. Thus, a rational request for active euthanasia is simply

¹²⁴ H. Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands' (1987) 8 *Health Policy* 197, 205; Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 518-519.

¹²⁵ See above, 179-187.

¹²⁶ Williams, *The Sanctity of Life and the Criminal Law*, 278; Morris, 248-251.

¹²⁷ For example, in the works of Locke, *Second Treatise*, in *Two Treatises of Government* (P. Laslett ed. 1960); Rousseau, *The Social Contract*, in the *Social Contract and Discourses* (G. Cole translation 1950); Kant, *Foundations of the Metaphysics of Morals* (1959).

¹²⁸ Support for the existence of a right to life can also be derived from international human rights instruments; see above, n. 46.

¹²⁹ See chapter I, 16-18.

¹³⁰ J. Feinberg, 'Voluntary Euthanasia and the Inalienable Right to Life' in J. Feinberg, *Rights, Justice, and the Bounds of Liberty* (1980) 220-275. See also M. Kohl, 'Euthanasia and the Right to Life', in S. Spicker and H. Engelhardt, (eds.) *Philosophical Medical Ethics* (1975) 73.

¹³¹ Kluge, *Ethics of Deliberate Death*, 103.

an exercise of one's right to life, in the sense of being able to exercise one's own choice, rather than an attempt to alienate the inalienable.¹³²

Acceptance of Active Voluntary Euthanasia Would Create a Duty to Kill

Another fundamental objection to active voluntary euthanasia is that the creation of a right to seek active euthanasia would impose on others a correlative duty to kill.¹³³ It is certainly true that the concept of rights, in its strict sense, has generally been understood to entail correlative duties or obligations.¹³⁴ However, as an absolute argument against the legalisation of active voluntary euthanasia, it is seriously flawed, since it proceeds on the assumption that a scheme of legalised euthanasia would necessarily create legal rights and duties. As was earlier observed, a rights-based model is not a suitable basis for implementing active voluntary euthanasia. If active voluntary euthanasia were to be legalised, it would be far preferable to avoid this rights/duties analysis altogether by vesting in patients a *liberty* to seek active euthanasia and *permitting* doctors to perform active euthanasia at the request of a patient without creating any *duty* to do so.

Practical Arguments Against Active Voluntary Euthanasia

As noted earlier, the objections of many opponents of euthanasia are based, not on the inherent wrongfulness of individual acts of active voluntary euthanasia, (which they concede may be moral and in the interests of the individual in exceptional cases,) but arise out of concern for the long term consequences if the practice of active voluntary euthanasia is institutionalised.¹³⁵ On the basis of this argument, no matter what view one takes of individual instances of active voluntary euthanasia, as a matter of social policy we ought to enforce a rigorous rule against it.¹³⁶ The leading opponent of active voluntary euthanasia on pragmatic grounds is undoubtedly Kamisar, through his much celebrated work, 'Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation' in which a range of practical objections to the legalisation of active voluntary euthanasia are raised.¹³⁷ Unlike doctrinaire objections, which can more readily be dismissed on the grounds that they are 'uncritical universal negatives, not open to ethical reasoning or conscientious judgment',¹³⁸

¹³² Feinberg, 'Voluntary Euthanasia and the Inalienable Right to Life,' 220-275; D. Brock, 'Voluntary Active Euthanasia' (1992) 22 *Hastings Centre R.* 10, 14. For a contrary view, see D. Callahan, 'Aid-In-Dying: The Social Dimension' (1991) 118 *Commonweal* 476, 477-478.

¹³³ A number of opponents of legalisation have raised this objection; e.g. T. Campbell, 'Euthanasia and the Law' 17 (1979) *Alta.L.Rev.* 188, 189; Potts, 509; H. Caton, 'Difficulties of Dying' (1991) *Policy* 32, 35; N. Tonti-Fillippini, 'The Right to Die - Philosophical Aspects,' paper delivered at the Pro-Life Victoria Seminar - Death With Dignity: Is Living Will Legislation the Answer? 27 Aug. (1983) 6.

¹³⁴ See above, 186-187.

¹³⁵ For example, Kamisar, 975; Potts, 504-509; Callahan, 'Aid-In-Dying: The Social Dimension', 476-480; R. Weir, *Abating Treatment with Critically Ill Patients*, 417; P. Foot, 'Euthanasia' (1977) 6 *Phil. & Public Affairs* 85-112. For a discussion of the distinction between individual cases of active voluntary euthanasia and the development of a social policy, see Gula, 'Moral Principles Shaping Public Policy on Euthanasia', 74-82.

¹³⁶ Rachels, *The End of Life*, 172.

¹³⁷ (1958) 42 *Minn.L.Rev.* 969.

¹³⁸ Fletcher, 'The Courts and Euthanasia', 229.

objections based on pragmatic considerations are, by their very nature, of greater practical relevance, requiring close and careful examination.

The Wedge Argument

The most popular objection to the legalisation of active voluntary euthanasia is the 'slippery slope' or 'thin edge of the wedge' argument. The wedge argument against active voluntary euthanasia has two forms. One form of the argument is that the legalisation of active voluntary euthanasia *logically entails* non-voluntary and involuntary euthanasia.¹³⁹ It will be demonstrated that this form of the argument ignores the vital distinction between voluntary euthanasia and non-voluntary and involuntary euthanasia.¹⁴⁰ The second form of the wedge argument is that whilst the legalisation of active voluntary euthanasia does not logically entail involuntary euthanasia, this will inevitably be the result if the first domino is allowed to fall.¹⁴¹ Thus, the wedge argument is essentially that the legalisation of active voluntary euthanasia would lead to widespread involuntary euthanasia and the termination of lives no longer considered socially useful. The classic statement of the wedge argument is to be found in the scholarly writing of Kamisar, but it is also a basis of Christian opposition to euthanasia.¹⁴² The argument has gained new impetus in the modern medical context where there is growing concern over limited medical resources and escalating health care costs.¹⁴³ The fear is that the perceived economic benefits which may be derived from the legalisation of active voluntary euthanasia could result in an expanding category of patients for whom active euthanasia is permitted.

Proponents of the wedge argument refer, almost inevitably, to the atrocities which took place in Nazi Germany in support of their contention that taking the first, albeit small, step on the slippery slope, will result in wrongs of ever increasing magnitude.¹⁴⁴ However, closer examination of German history reveals that the concept of euthanasia from which the Nazi atrocities allegedly developed, was completely removed from the contemporary notion of active voluntary euthanasia as a merciful release from suffering performed at the patient's request.

The program of euthanasia in Germany had its origins in a highly influential book written by Binding and Hoche in 1920 entitled, 'Permission to Destroy Life not Worth Living'.¹⁴⁵ In this work, Karl Binding, a leading jurist, and Alfred Hoche, a well known psychiatrist, advocated the killing of 'worthless people' in order to relieve society of the burden of their care. The book was immensely popular and its underlying concept of 'a life not worth living' was to subsequently shape German medical and ethical thinking. The essence of this concept was that some lives are completely devoid of

¹³⁹ See J. Feinberg, *The Moral Limits of the Criminal Law* Vol. III, *Harm to Self* (1986) 346; and Rachels, *The End of Life*, 172-175; where they both discuss the forms of the argument.

¹⁴⁰ See the Introduction to this thesis, 6 for consideration of this distinction.

¹⁴¹ See discussed in Feinberg, *Harm to Self*, 346. In this context, opponents refer mainly to involuntary euthanasia.

¹⁴² Sullivan, 54-57; N. St. John Stevas, *Life Death and the Law* (1961) 273-274.

¹⁴³ For an example of the expression of this concern, see R. Twycross, 'Assisted Death: A Reply' (1990) 336 *Lancet* 796, 797.

¹⁴⁴ Kamisar, 1030-1041.

¹⁴⁵ K. Binding and A. Hoche, *Die Freigabe der Vernichtung Lebensunwerten Lebens. Ihr Mass and ihre Form* Verlag von Felix Meiners in Leipzig (1920).

value and should therefore be terminated. Initially, in the 1930s, programs were introduced for the elimination of incurables, the mentally-ill and defective. However, with the growth of Nazi fanaticism, the concept of 'a life not worth living' later came to be used as a justification for genocide.¹⁴⁶ The argument of euthanasia opponents is that the atrocities of Nazi Germany had started from small beginnings, namely with the acceptance of the attitude that there is such a thing as 'a life not worth living'¹⁴⁷ and therefore, active voluntary euthanasia must not be legalised, lest the same consequences result.

The Nazi experience is undeniably a lasting blemish on humanity, and no attempt will be made to diminish the horror or significance of this period in German history. However, the Nazi analogy is simply inapplicable to the contemporary notion of active voluntary euthanasia. As we have seen, the Nazi programme of euthanasia developed from the concept of 'a life not worth living'. It was neither voluntary nor based on compassion but, rather, was motivated by the desire to preserve the purity of the 'Volk' and rid the country of useless eaters. The Nazi experience certainly serves as a salutary warning of the dangers inherent in a policy of euthanasia based on the concept of 'a life not worth living' which, because of its indeterminacy, invites extension and abuse. However, the contemporary notion of active voluntary euthanasia which is being advanced in this thesis, is based upon quite a different premise, namely the patient's freedom of choice and right of self-determination. The suggestion made by some commentators¹⁴⁸ that the concept of active voluntary euthanasia necessarily involves acceptance of a policy that certain lives are not worth living is flatly rejected as being both misleading and inaccurate. As was stressed earlier, respect for a patient's right of self-determination does not involve an objective assessment about the value or worth of that life.¹⁴⁹

It is frequently alleged that proponents of active voluntary euthanasia have a broader secret agenda, with objectives extending well beyond voluntary euthanasia. Indeed, it has been suggested that the strategy of the euthanasia movement has been to deliberately use the wedge principle to their own advantage; to secure initially the legalisation of active voluntary euthanasia, and once this becomes accepted as standard practice, they will introduce more ambitious and far-reaching reforms.¹⁵⁰ Whilst the general thrust of the euthanasia movement in recent years has been confined to legalisation of active voluntary euthanasia, there are undoubtedly some extremists amongst euthanasia advocates, particularly those drawing their support from utilitarian arguments, who would be in favour of a

¹⁴⁶ For detailed analysis of the history of euthanasia in Germany, see; van der Sluis, 137-148, 154-160; L. Alexander, 'Medical Science Under Dictatorship' (1949) 241 *New Eng.J.Med.* 39; F. Wertham, 'Euthanasia Murders' in Horan and Mall, 602-641.

¹⁴⁷ Alexander, 44.

¹⁴⁸ For example, R. Sherlock, 'Public Policy and the Life Not Worth Living: The Case Against Euthanasia' (1980) 47 *Linacre Q.* 121; C. Rice, *The Vanishing Right to Life* (1969) 61; Gormally, 72, 74-76. A number of Australian commentators have expressed similar views; e.g. N. Tonti-Fillippini, 'Death and Dying - The Ethical Issues' 15, 17 in Proceedings of a Public Meeting on Euthanasia and Infanticide, St. Vincent's Bioethics Centre, 4 March (1986). Note also K. Andrews, 'The Refusal of Medical Treatment Bill and the 'Living Will' Legislation' (1984) 2 *Lawyer* 13.

¹⁴⁹ See above, 180.

¹⁵⁰ For example, Kamisar, 1015.

broader basis for active euthanasia.¹⁵¹ However, a very real and significant distinction exists between voluntary euthanasia on the one hand, and involuntary or even non-voluntary euthanasia on the other, and this distinction must be firmly borne in mind in evaluating the wedge argument. Provided that the individual's choice is treated as determinative, there is a sufficiently clear line to prevent the imposition of active euthanasia on non-consenting patients. What must be emphasised is that the objective of active voluntary euthanasia is the promotion of individual autonomy and self-determination rather than any sinister aim of human disposal. Recognition of patient autonomy and self-determination is thus a clear limiting principle against abuse. So long as this crucial distinction between voluntary and involuntary/non-voluntary euthanasia is understood, the first form of the wedge argument, namely that legalisation of active voluntary euthanasia logically entails involuntary euthanasia, can be unequivocally rejected.¹⁵²

The wedge argument in its second form, based upon the inevitable slide towards involuntary euthanasia, is a stronger argument and seemingly more difficult to refute. Notwithstanding the popularity of this argument, there has been wide recognition that it is an argument which must be treated with caution since it could be used as a basis for the opposition of virtually any social policy.¹⁵³ Furthermore, since we are dealing with the fundamental notion of self-determination, it becomes necessary to weigh up whether the risks posed by the legalisation of active voluntary euthanasia are both sufficiently grave and sufficiently certain to outweigh the patient's right of self-determination. There would be little dispute regarding the gravity of the risk of involuntary and even non-voluntary euthanasia. However, in order for the wedge argument to be persuasive, it must be evident that the feared consequences which are alleged to flow from the legalisation of active voluntary euthanasia are reasonably likely to occur. The mere *possibility* that a law permitting active voluntary euthanasia may be broadened in the future is not a sufficient justification for refusing to allow its enactment. Furthermore, since a strong moral case can be presented for the legalisation of active voluntary euthanasia, it is incumbent on the opponents of reform to provide convincing evidence that these feared consequences are indeed likely. It is at this point that the wedge objection fails to stand up to scrutiny. Having earlier dispensed with the Nazi analogy, there is simply no empirical evidence to suggest that the acceptance of active voluntary euthanasia on a strictly limited basis would be the 'thin edge of the wedge.' Indeed, there is significant evidence to the contrary; since 1970, active voluntary euthanasia has been practised in the Netherlands yet there is no evidence to suggest that this has represented a step onto the slippery slope, leading to involuntary euthanasia.¹⁵⁴ Furthermore, it could be argued by analogy that the liberalisation of the law with regard to infanticide and suicide during the course of this century has not resulted in a diminution in respect for human life. In the final analysis,

¹⁵¹ For example, Kohl, *The Morality of Mercy Killing*; G. Williams, *The Sanctity of Life and the Criminal Law*, 310-312; Young, 279-282; Rachels, *The End of Life*; P. Singer, 127-157.

¹⁵² See also Rachels, *The End of Life*, 172-173.

¹⁵³ For example, Williams, *The Sanctity of Life and the Criminal Law*, 280-281; G. Williams, 'Euthanasia Legislation: A Rejoinder to Non-Religious Objections', 156, 165-166; President's Commission Report, 29-30; Brock, 19-20.

¹⁵⁴ See chapter VIII, 387-392.

the wedge objection is an argument easily raised, but totally unsupportable and should therefore be dismissed.¹⁵⁵

Some commentators have sought to refute the wedge objection on different grounds; they point out that passive euthanasia is now common practice and since there is no intrinsic moral difference between active and passive euthanasia, they argue that if indeed there is a 'slippery slope' then we are already on it.¹⁵⁶ Thus, it is argued, there is no logical basis for objection to active voluntary euthanasia since it is essentially equivalent to the existing practice of passive euthanasia. It is further argued that rather than seeking to prohibit active voluntary euthanasia, it would be better to bring all life and death decisions out into the open where there can be the widest possible debate and public scrutiny.¹⁵⁷

The validity of this argument depends on acceptance of the view that there is no morally relevant difference between passive and active euthanasia - a view which is by no means universally endorsed.¹⁵⁸ This line of argument does, however, highlight the artificiality in maintaining rigid distinctions between active and passive voluntary euthanasia, when they are often so similar in relevant respects.¹⁵⁹

For all of the foregoing reasons, slippery slope arguments do not provide a sufficient justification to retain the existing prohibition on active voluntary euthanasia; while the possibility of bad consequences should encourage us to proceed cautiously; it should not prevent us from proceeding at all.¹⁶⁰

Effect on Social Fabric of Society

Closely connected with the wedge argument is the objection that the legalisation of active voluntary euthanasia would have the effect of substantially damaging the moral and social fabric of society.¹⁶¹ It is argued that any lessening of the traditional common law prohibition on killing would

¹⁵⁵ Commentators have sought to find support for their rejection of slippery slope arguments by drawing on other examples of deliberate killing which have defied the slippery slope analysis. See, for example, Rachels, *The End of Life*, 174-175; Browne, 47; Williams, 'Euthanasia and Abortion,' 181. One predictable way in which attempts may be made in the United States to extend the practice of active euthanasia if it were legalised would be in the direction of non-voluntary euthanasia for incompetent patients; see Callahan, 'Aid-In-Dying: The Social Dimension', 478-479. As noted in an chapter II, the courts in the United States have sought to equate the rights of competent and incompetent patients and it is quite possible that if active voluntary euthanasia were legalised, attempts would be made to extend the same opportunity to incompetent patients, for example, through the doctrine of substituted judgment. However, this does not constitute an insurmountable objection to the legalisation of active voluntary euthanasia, since legislation could be framed in such a way that it that would apply only to presently competent patients.

¹⁵⁶ H. Kuhse, 'Taking Patient's Rights and Interests Seriously,' 18-19; H. Kuhse, 'The Alleged Peril of Active Voluntary Euthanasia: A Reply to Alexander Morgan Capron' (1987) 2 *Euthanasia Rev.* 60, 67-70.

¹⁵⁷ Kuhse, 'Taking Patient's Rights and Interests Seriously', 19.

¹⁵⁸ For discussion, see above, 181-183.

¹⁵⁹ For example, in relation to intention and outcome.

¹⁶⁰ Rachels, *The End of Life*, 175.

¹⁶¹ A number of commentators have advanced this argument; e.g. Shewmon, 221; M. Heifetz with C. Mangel, *The Right to Die* (1975) 108-109; Grisez, 803; Potts, 506; D. Louisell, 'Euthanasia and Biathanasia: On Dying and Killing' (1973) 22 *Catholic U.L.Rev.* 723, 742.

dehumanise society and result in a reduced respect for human life.¹⁶² There is particular concern that persons involved in the practice of active euthanasia, whether directly or indirectly, would become brutalised and less caring and vigilant about the value of human life.

In a sense this is simply a restatement of the wedge argument; it is feared that if the barriers to killing are lowered, the practice of active euthanasia may be extended beyond that which is originally envisaged. However, apart from concerns about 'slippery slopes,' this argument also appears to suggest that a society which allows active voluntary euthanasia is inevitably morally and socially inferior to a society which prohibits its practice. To begin with, one may wonder how the moral and social quality of society can reliably be gauged, and there is a temptation to summarily reject this objection on the grounds that it is impossibly vague and indeterminable. But even if this objection were to be taken seriously, it can be countered on the basis that existing laws allow the practice of *passive* euthanasia, as well as certain forms of killing which have been deemed justified, for example, killing in war, or in self-defence, yet there has been no convincing evidence to suggest that this has damaged the essential fabric of society. It therefore seems invalid (particularly in the light of arguments that there is no morally relevant difference between active and passive euthanasia) to categorically assert that to allow active euthanasia performed at the request of the patient in order to relieve the patient's pain and suffering will necessarily diminish respect for the sanctity of life and result in the moral and social decline of society. In fact, if we look to the Netherlands, where active voluntary euthanasia is now openly practiced by doctors, there has been no evidence of such decline.¹⁶³ Indeed, it could be argued that facilitating a gentle and easy death at the patient's request is a moral advance rather than a moral decline; active euthanasia, at the patient's request, is a merciful and benevolent act which promotes desirable virtues in society, and since it furthers the principle of individual self-determination it enhances, rather than diminishes, respect for human life.¹⁶⁴ According to this view, it is the present prohibition of active voluntary euthanasia which amounts to brutalisation of society. For the foregoing reasons, this objection to the practice of active voluntary euthanasia ought to be rejected.

Problems in Ascertaining Patient Consent, Feared Abuses and Risk of Error

Consideration will now turn to a number of objections to legalisation of active voluntary euthanasia which focus on the problems of ascertaining a truly voluntary consent from the patient as well as concerns about feared abuse and risk or error if active voluntary euthanasia were legalised. It will be demonstrated that these are essentially paternalistic arguments which, if accepted, would have the effect of unjustifiably limiting patient autonomy.

¹⁶² See, for example, Grisez, 803; Veatch, 86-90.

¹⁶³ See chapter VIII, 391. Note also the view in the Institute of Medical Ethics, Working Party Discussion Paper, 611 where it is noted that cases of doctors occasionally assisting the deaths of their patients have occurred without any consequent moral decline.

¹⁶⁴ M. Angell, 'Euthanasia' (1988) 319 *New Eng.J.Med.* 1348, 1350.

Voluntariness and Patient Consent

A major objection which has been raised to the legalisation of active voluntary euthanasia relates to the issue of patient competence and decision-making capacity, and the difficulties involved in determining whether the patient's request for death represents a free and rational choice.¹⁶⁵ There are a number of facets to this argument. One aspect of the argument is that if consent is not given until the final painful stages of a terminal illness, the patient may be so effected by pain, mental anguish or the stupefying effects of pain-relieving drugs that he or she is incapable of giving a free and rational consent. The mental and physical condition of a seriously ill patient may fluctuate and the patient may be subject to confusional states¹⁶⁶ impairing the patient's decision-making capacity. Even where an apparently clear request for active euthanasia has been made, the patient may subsequently vacillate in his or her decision. It is argued by opponents that as a result of possible confusion, impairment and vacillation, it often becomes very difficult to accurately gauge the reliability of a patient's request. Furthermore, it is not uncommon for terminal patients to suffer from depression,¹⁶⁷ and opponents maintain that a request for death may simply be an impulsive and transient response to the patient's difficult circumstances and may, therefore, be inherently unreliable.¹⁶⁸

If, on the other hand, consent is given in *advance* of the onset of pain and administration of medication, it is argued by opponents that the consent cannot be sufficiently informed and will not necessarily represent the true wishes of the patient at a later stage.¹⁶⁹

Opponents also claim that there may be problems in interpreting a patient's request: what may appear to be a voluntary request to die may in fact be a call for help or support and may, therefore, not reflect the patient's autonomous choice.¹⁷⁰

These objections must be taken seriously, since the voluntariness of the patient's consent is undoubtedly of vital importance to the question of legalisation of active voluntary euthanasia. There are, however, inherent limitations in this area and it is unrealistic to strive for absolute certainty. At the same time, the problems concerning the reliability of a terminal patient's request for death should not be overstated.¹⁷¹

¹⁶⁵ For example, Kamisar, 985-990; Rice, 55-57; Law Reform Commission of Canada, Working Paper No. 28, *Euthanasia, Aiding Suicide and the Cessation of Treatment* (1982) 46-47 (hereafter referred to as the Law Reform Commission of Canada Working Paper on Euthanasia). A Report of the same title was subsequently released, but references are to the Working Paper where there is more detailed analysis of these issues.

¹⁶⁶ For example, A. Stedeford, 'Confusional States' in R. Twycross and V. Ventafridda, (eds.) *The Continuing Care of Terminal Cancer Patients* (1980) 179-192.

¹⁶⁷ See E. Kubler-Ross, *On Death and Dying* (1969) where she identified five emotional stages that a dying patient could experience, including depression (75-98).

¹⁶⁸ Some evidence can be cited in support of these claims; in a study of patients who had requested to die, many were found to be depressed. See H. Brown *et al.*, 'Is it Normal for Terminally Ill Patients to Desire Death?' (1986) 143 *Am.J. Psychiatry* 208.

¹⁶⁹ See Kamisar, 989-990.

¹⁷⁰ H. Zwart, 'Psychology, Self-Determination and the Veil' in O. Aycke and M. Smook (eds.) *Right to Self-Determination* (1990) 33; J. Lynn, 'The Health Care Professional's Role When Active Euthanasia Is Sought' (1988) 4 *J. Palliative Care* 100, 100.

¹⁷¹ Some support for the stability of patient preferences can be derived from a study conducted by M. Everhart and R. Pearlman dealing with patients' attitudes to life-sustaining treatment; 'Stability of

With regard to the first basis of the objection, the decision-making capacity of patients cannot be categorically denied simply because they are in a terminal state. This would represent an unjustifiable infringement of patient autonomy. Whilst some patients may be so affected that they are no longer able to exercise an autonomous choice, there will be others who will be capable of doing so even in the terminal stages of their illness. Further, it should be pointed out that these problems are not unique to the issue of active voluntary euthanasia. The issues of patient decision-making capacity and voluntariness of consent arise in virtually all areas of medical practice, including cases of refusal of treatment. Although there may be difficulties in determining whether a patient has decision-making capacity in a particular case, it would be unrealistic to suggest that a patient can never give a valid consent to the withdrawal of treatment. Similarly with active voluntary euthanasia; although difficulties will inevitably be encountered in ascertaining the voluntariness of a patient's consent, these difficulties are not insurmountable and certainly do not justify a blanket prohibition on the practice. Indeed, it would be inconsistent to accept that a patient can voluntarily choose passive euthanasia by refusing treatment, but not active euthanasia, since both involve the choice of an earlier death.¹⁷²

The second aspect of the opponents' argument can also be countered. It is simply unreasonable to contend that a patient can never be sufficiently informed to make an advance request to die. Whether an advance request to die in a particular case is sufficiently informed will of course depend on the circumstances, but provided the patient is given adequate information about his or her condition and prognosis, there is no reason to suggest that the patient is incapable of making an informed decision. Particularly where the earlier request to die is subsequently reiterated after the onset of pain and medication, there is every justification for assuming that the patient has made an informed and voluntary choice.

Concerns regarding the interpretation of a patient's request for active euthanasia can also be countered. Whilst some situations are truly ambiguous, serious requests for active euthanasia can be separated from those that reflect symbolic gestures for assistance or attention.¹⁷³

The various concerns of the opponents regarding voluntariness of patient consent can be adequately addressed through appropriate regulation of the practice of active voluntary euthanasia.¹⁷⁴ Such regulation would include requirements that: 1) a professional assessment is made of the patient's decision-making capacity; 2) the patient is appraised of sufficient facts to give an 'informed consent'; 3) that the patient's request must be repeated on several occasions over an extended period of time

Patient Preferences Regarding Life-Sustaining Treatments' (1990) 97 *Chest* 159. In this study it was found that despite significant changes in health status and mood, treatment preferences were stable over time.

¹⁷² H. Kuhse, 'The Case for Active Voluntary Euthanasia,' 147.

¹⁷³ L. Churchill, 'Examining the Ethics of Active Euthanasia' (1990) 5 *Med. Ethics for the Physician* 16, 17.

¹⁷⁴ For further discussion, see chapter IX, 412-425.

before it is acted upon; and 4) that the patient be allowed to revoke the request at any time, regardless of the patient's physical or mental condition.¹⁷⁵ Such measures would largely reduce the possibility of doctors acting upon mistaken or inappropriate requests.¹⁷⁶

One question which may be raised is whether the patient's request for active euthanasia must be objectively reasonable before it can be regarded as a valid and voluntary consent. From the outset it should be acknowledged that in the majority of cases, a patient's request for death which is the product of reflection and made in circumstances where the patient has no prospect of recovery, is likely to be a rational and reasonable request. This conclusion is supported by evidence from surveys of doctors who have been confronted with such requests.¹⁷⁷ However, as was argued earlier in this chapter, provided the patient has decision-making capacity, his or her self-determination ought to be respected and it is not appropriate for others to become involved in judging the objective reasonableness of the patient's request.¹⁷⁸ An analogy can be drawn here with the refusal of treatment of cases; in that context, it has been accepted by the courts that a patient who has decision-making capacity has a right to refuse treatment, no matter how unreasonable or foolish that refusal may seem to the patient's medical advisers.¹⁷⁹ Moreover, the courts have recognised that the apparent unreasonableness of a patient's decision does not justify the conclusion that he or she is incompetent in the legal sense.¹⁸⁰ If this position is accepted in the context of the patient's right to refuse treatment there is no justification for denying the same recognition to the patient's right of self-determination in the context of active euthanasia.

Feared Abuses and Other Problems

Possibility of Abuse by Unscrupulous Parties

Closely connected with the issue of voluntariness of the patient's consent is the objection that the legalisation of active voluntary euthanasia would result in abuses of the practice.¹⁸¹ In particular, there is concern that unscrupulous doctors or family members may take advantage of the law to conceal a conspiracy to murder a patient.¹⁸²

¹⁷⁵ See also Arras, 300.

¹⁷⁶ Churchill, 17.

¹⁷⁷ H. Kuhse and P. Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 *M.J.A.* 623, 623-624; T. Robertson and S. Tobin, 'A Survey of the Attitudes of Doctors and Medical Students Towards Active Voluntary Euthanasia', (unpublished manuscript, Flinders Medical Centre 1989) 34, 54.

¹⁷⁸ See above, 180.

¹⁷⁹ See McHugh J. of the High Court in *Secretary, Department of Health and Community Services v J.W.B. and S.M.B.* 6 May 1992 F.C. 92/010, 91-92, (at the time of writing this decision had not yet been published); *Smith v Auckland Hospital Board* [1965] N.Z.L.R. 191, 219; *Lane v Candura* 376 N.E. 2d 1232 (1978).

¹⁸⁰ *Lane v Candura* 376 N.E. 2d 1232 (1978).

¹⁸¹ President's Commission Report, 79-80.

¹⁸² For example, L. Kass, 'Neither for Love Nor Money: Why Doctors Must Not Kill' (1989) 94 *Public Interest* 25, 35-36.

It cannot be disputed that abuses may occur if active voluntary euthanasia were legalised; the reality is that all laws are potentially open to abuse. All the same, the opponents' objection does not appear to be compelling. First, it could be argued that the present practice of active euthanasia in an illegal and unregulated form is likely to involve some degree of abuse and there is every reason to believe that legalisation of the practice, with appropriate regulatory procedures, would reduce the possibility of covert and improper practices.¹⁸³ In any event, as a number of commentators have pointed out,¹⁸⁴ the possibility of abuse already exists with respect to passive euthanasia, which may in fact offer a greater opportunity for abuse since the patient's death may be easier to conceal than from a killing by more direct means.

The possibility, or even the strong likelihood, of some abuse occurring if active voluntary euthanasia is legalised is not of itself sufficient to completely prohibit the practice, if, as has been suggested, there are powerful arguments for legalisation. Whilst abuses will inevitably result, the risk of abuse can be minimised by the imposition of stringent safeguards regulating the practice.¹⁸⁵

Pressure on the Patient

Some opponents argue that abuse may take a more subtle form of pressure being exerted on the patient to request active euthanasia.¹⁸⁶ Their argument is that chronically and terminally ill patients are often vulnerable and perceive themselves to be a burden on others. If active voluntary euthanasia were to become readily available, eligible patients may feel under a *duty* to request it, particularly if relatives or hospital staff exert pressure on patients to do so and thereby relieve them of the financial and social burden of their care. Thus, it is argued that legalising active voluntary euthanasia would be to risk putting to death many patients who do not genuinely wish to die but who are pressured into requesting active euthanasia.

This is essentially an argument relating to the voluntariness of the patient's consent and reflects the paternalistic stance of many of the opponents of legalisation. There is no doubt that in some instances patients may be pressured or feel obliged to request active euthanasia. However, given the benefits which would flow from the legalisation of active voluntary euthanasia, and the fact that abuses can be adequately guarded against, this should not be taken as a decisive objection to the practice. In other areas of the law, including refusal of treatment, problems of coercion and consent have had to be dealt with. As part and parcel of the legalisation of active voluntary euthanasia, it would not be impossible to devise procedures which would minimise the risk of the patient's consent being undermined by

¹⁸³ For example, Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 519; H. Kuhse and R. Young, 'A Rejoinder to Some Common Objections to the Legalisation of Euthanasia,' paper delivered at the ANZAAS Symposium, 'Modern Medical Technology and the Right to Die' (1985) 16; N. Newman, 'Euthanasia: Orchestrating "The Last Syllable of...Time"' (1991) 53 *U.Pitt.L.Rev.* 153, 177; Nowell-Smith, 90.

¹⁸⁴ For example, Kuhse, 'The Alleged Peril of Active Voluntary Euthanasia: A Reply to Alexander Morgan Capron', 65; Richter, 65-66.

¹⁸⁵ Morris, 259. Safeguards could, for example, include the requirement that the patient's request be witnessed by two independent persons, that official records be kept, and that the attending doctor's diagnosis is confirmed by another doctor. See further, chapter IX, 412-425.

¹⁸⁶ For example, Kamisar, 990-991; Potts, 505-506; I. van der Sluis, 'How Voluntary is Voluntary Euthanasia?' (1988) 4 *J. Palliative Care* 107, 107-108.

subtle familial coercion or influence. For example, as part of the procedure for the assessment of a patient's request for active euthanasia, possible sources of coercion would have to be investigated to ensure that the patient's request is truly voluntary.¹⁸⁷ It is far more appropriate and consistent with principles of self-determination to try and guard against coercion and improper influence, rather than to deny to all the possibility of electing an earlier death.

Possibility of Error

A number of the arguments that have been advanced against legalisation of active voluntary euthanasia have been based on the possibility of error in diagnosis or prognosis or the possibility of a cure being discovered which may save the life of the patient. These objections can, however, readily be countered on the grounds that they are unjustifiably paternalistic and are completely contrary to the fundamental principle of patient self-determination.

Possibility of Mistaken Diagnosis

A common objection to the legalisation of active voluntary euthanasia is that doctors are fallible and may be mistaken in their diagnosis of illness or in their assessment of prognosis for recovery.¹⁸⁸ Opponents point out that if a doctor mistakenly diagnoses a patient as terminal, and on the basis of that diagnosis, the patient requests and receives active euthanasia, a life will have been unnecessarily and irreversibly extinguished. Unlike in the case of passive euthanasia, where a patient may survive a prognostic mistake, if active euthanasia is administered, the mistake becomes self-fulfilling.¹⁸⁹ Accordingly, it is argued, in order to avoid the risks of mistaken diagnosis or prognosis, active voluntary euthanasia must be completely prohibited.

While the chance of mistaken diagnosis or prognosis in cases of advanced terminal illness is highly improbable, it cannot be ruled out entirely; the possibility of error exists in all human actions. These risks can, however, be minimised by requiring that the patient is seen by more than one doctor before active voluntary euthanasia is authorised. But most importantly, the patient must be informed of the possibility of error, in order that he or she can make an informed and rational choice.¹⁹⁰ It is a fundamental part of autonomous decision-making that the patient be allowed to weigh up the available information and elect to act upon it even if there is a small chance that the information may be

¹⁸⁷ See also the Institute of Medical Ethics, Working Party Discussion Paper, 611 where it is suggested that it would not normally be difficult for the doctor to discern that family pressure is the reason for the request. But see also the criticism of this view by Twycross, 'Assisted Death: A Reply', 797. In any event it could be argued that the fact that a patient's request for active euthanasia is in part based on a desire to relieve emotional and financial pressures on family, should not, of itself, render the patient's consent inoperative; see also J. Glover, *Causing Death, Saving Lives* (1977) 187 where he questions whether a paternalistic refusal to carry out the patient's wishes in these circumstances would be justified. See also Young, 270; Williams, 'Euthanasia Legislation: A Rejoinder to the Non-Religious Objections,' 156, 160.

¹⁸⁸ For example, Kamisar, 993-998; Rice, 57-59; Keyserlingk, *Sanctity of life or Quality of Life* 126; Law Reform Commission of Canada Working Paper on Euthanasia, 46.

¹⁸⁹ Capron, 55. But see the response of Kuhse, 'The Alleged Peril of Active Voluntary Euthanasia: A Reply to Alexander Morgan Capron', 62-62 where she points out that there are also many cases where a patient's decision to refuse life-sustaining treatment will make a mistaken prognosis equally self-fulfilling.

¹⁹⁰ Arras, 301-302.

incorrect. Whilst the possibility of mistaken diagnosis or prognosis requires extreme caution before a patient's condition is declared 'hopeless,' it does not constitute an adequate objection to the legalisation of active voluntary euthanasia.

Possibility of a Cure

A related clinical objection is that a cure or some measure of relief may be discovered within the natural life expectancy of the patient.¹⁹¹ Supporters of this argument contend that the administration of active voluntary euthanasia would foreclose the possibility of the patient being able to benefit from any new discovery and that it should, therefore, be prohibited.

It is certainly true that medical science is constantly advancing and the possibility always exists that a cure may be found for a condition previously considered hopeless. However, from a practical point of view, this possibility will only be of relevance to patients who have undergone euthanasia shortly before the discovery became readily available for use¹⁹² and who would have been able to expect a complete recovery from their condition. The reality is that usually, a considerable time elapses between the announcement of a new medical discovery and its implementation and availability for use. Even if the cure were immediately available, it would be unlikely to be able to reverse the condition of those patients with advanced terminal illness who are most likely to be seeking active voluntary euthanasia.¹⁹³ Ultimately, it comes down to a question of patient choice. As part of the counselling that a patient would receive before a request for active euthanasia is acted upon, the patient should be informed of the possibility (albeit remote) of a cure being discovered for his or her particular condition. This would be especially important in circumstances where a doctor is aware of a new medical break-through which is soon to become available. In this way, the patient can be fully informed before a decision is made with respect to active voluntary euthanasia. It is then for the patient, in the exercise of his or her self-determination, to evaluate the possible advantages of waiting for a possible cure as against seeking an early release from his or her suffering. It would be most unreasonable to deny all patients the freedom to elect active voluntary euthanasia on the ground that for some this interference with their free choice may mean the possibility of a cure.

The foregoing analysis of objections based on problems in ascertaining patient consent, feared abuses and risk of error gives rise to fundamental questions regarding patient autonomy. Opponents of legalisation of active voluntary euthanasia are undoubtedly sincere in their wish to protect patients from the risk of error or abuse and to avoid a request being acted upon which does not reflect the patient's genuine wishes. The question which must, however, be addressed is whether such objections are justifiable. More particularly, this involves the need to balance, on the one hand, the liberty interests of those patients who voluntarily seek active euthanasia and, on the other, the need to protect those who may be vulnerable to abuse or coercion from others or who may be mistakenly killed if

¹⁹¹ Kamisar, 998-1005; Law Reform Commission of Canada Working Paper on Euthanasia, 46.

¹⁹² Morris, 261.

¹⁹³ Morris, 261-262.

active voluntary euthanasia were legalised.¹⁹⁴ If the present prohibition on active voluntary euthanasia is retained, the choice of some patients will be denied and they will be forced to suffer against their will.¹⁹⁵ If, however, active voluntary euthanasia is legalised, there will be some risk of unwilling casualties as a result of error and abuse. The approach of opponents of legalisation has been to sacrifice the autonomy of patients genuinely seeking active euthanasia for the benefit of those who may be harmed if active voluntary euthanasia is legalised. Some opponents have attempted to justify their conclusion with claims that in numerical terms, the number of vulnerable persons who would be at risk if active voluntary euthanasia were legalised would be greater than those who would be forced to suffer against their will if the present prohibition is retained.¹⁹⁶ Apart from the fact that such numerical claims are purely speculative and may in fact be completely unfounded, it could be argued that the question raised is, in any event, far more complex, involving a balancing of values.¹⁹⁷ Ultimately, the principle of patient autonomy must prevail, notwithstanding that this may entail some risk of error and abuse, particularly since these risks can be adequately guarded against by the introduction of appropriate safeguards. It is also quite possible that legalisation would not in fact produce more mistakes and abuse than non-legalisation.¹⁹⁸

Practical Difficulties in Formulating Criteria for Active Voluntary Euthanasia

Another objection, which is really an extension of some of the preceding arguments, is that even if the concept of active voluntary euthanasia were accepted in principle, it would be extremely difficult, if not impossible, to formulate a legislative provision sufficiently precise to allow active voluntary euthanasia in appropriate cases, yet providing adequate safeguards against abuse.¹⁹⁹ Put more bluntly, it is sometimes contended that specific plans for active voluntary euthanasia are simply unworkable; if adequate provision were to be made to ensure that the patient has given a voluntary and informed consent, that the patient's condition has been confirmed by consultation with other doctors, and that potential mistakes and abuses have been guarded against, the procedure would become so cumbersome and time-consuming that it would be unable to fulfil its objective of providing the means for a swift and painless death. Indeed, Kamisar, one of the most forceful critics of legalisation of active voluntary euthanasia, has suggested that euthanasiasts are seeking a goal which is inherently inconsistent: a procedure for death which provides ample safeguards against abuse and mistake and which is, at the same time, 'quick' and 'easy' in operation.²⁰⁰

The fact that it would be difficult to devise guidelines applicable in all cases does not mean that this cannot or should not be undertaken. Whilst it is inevitable that an appropriate regulatory procedure for

¹⁹⁴ See also J.C. Fletcher, 'Is Euthanasia Ever Justifiable?' in P. Wiernik, (ed.) *Controversies in Oncology* (1982) 297, 314, 318; Lynn, 102; J. Feinberg, 'Overlooking the Merits of the Individual Case: An Unpromising Approach to the Right to Die' (1991) 4 *Ratio Juris*. 131.

¹⁹⁵ Lynn, 102.

¹⁹⁶ For example, J.C. Fletcher, 314; Lynn, 102.

¹⁹⁷ See also J. Feinberg, 'Overlooking the Merits of the Individual Case: An Unpromising Approach to the Right to Die', 140-151.

¹⁹⁸ For development of this argument, see Newman, 177-178.

¹⁹⁹ Kamisar, 978-985; Law Reform Commission of Canada Working Paper on Euthanasia, 47.

²⁰⁰ Kamisar, 982.

the legalisation of active voluntary euthanasia will, to some extent, cause delays in providing the desired result, this is not a valid reason to completely deny active voluntary euthanasia. Furthermore, opponents have tended to exaggerate the extent of the regulatory machinery necessary to effectively implement active voluntary euthanasia and the degree to which this will impede delivery of the service desired.

Euthanasia is an Unnecessary and Inappropriate Response

An alternative form of argument proceeds on the basis that active voluntary euthanasia is an unnecessary and inappropriate response to the patient's circumstances. There are a number of distinct components to this line of reasoning; that in light of developments in modern palliative care, there is no significant qualitative nor quantitative need for active voluntary euthanasia, that the final days of a patient's life may bring unexpected joy and fulfilment which the patient should not be denied and that in any event, legislative change is unnecessary since the present laws deal adequately with the situation. Each of these assertions will be examined in turn.

Capacity for Pain Relief

Opponents of euthanasia are frequently heard to say that legalisation of active voluntary euthanasia is unnecessary in light of modern developments in palliative care.²⁰¹ It is alleged that modern analgesics and narcotics can control pain and represent a safer and more positive response to the problems of the terminally or incurably ill than active voluntary euthanasia.²⁰²

Whilst it is true that there have been significant advancements in recent years in the area of palliative care, and that in most instances, dying patients can be made comfortable and their pain can be relieved, specialists in the area concede that it is not possible to eliminate pain in all cases.²⁰³ Furthermore, the practical realities of medical care often fall far short of the results achievable through optimal treatment.

However, more fundamentally, even if it *were* possible to relieve all physical pain, that would not obviate the need for active voluntary euthanasia.²⁰⁴ For many patients, there are aspects of dying that drugs and other forms of palliative care cannot alleviate, including the suffering and distress of their condition,²⁰⁵ the mental and emotional anguish, and the fear of dependency and degradation.²⁰⁶

²⁰¹ *Id.* 1008-1011; Pollard, *Euthanasia* 4, 37-38, 65, 132-133; Capron, 58; M. Connolly, 'Alternatives to Euthanasia: Pain Management' (1989) 4 *Issues Law & Med.* 497.

²⁰² Law Reform Commission of Canada Working Paper on Euthanasia, 48. See also R. Twycross, 'Voluntary Euthanasia' in S. Wallace and A. Eser (eds.) *Suicide and Euthanasia* (1981) 88-98.

²⁰³ This conclusion is based upon extensive interview work with specialists and is confirmed in the medical literature; e.g. J. Hockley, R. Dunlop and R. Davies, 'Survey of Distressing Symptoms in Dying Patients and their Families in Hospital and the Response to a Symptom Control Team' (1988) 296 *B.M.J.* 1715, 1715-1717.

²⁰⁴ See also M. Parker, 30; M. Ashby and B. Stoffell, 'Therapeutic Ratio and Defined Phases: Proposal of an Ethical Framework for Palliative Care', paper delivered at the Australian Bioethics Association Conference, 'Bioethics and the Wider Community' (1991) 9, 15.

²⁰⁵ Williams, 'Euthanasia Legislation: A Rejoinder to Non-Religious Objections', 156, 164.

²⁰⁶ For medical recognition of unrelieved pain and other distressing symptoms in the dying, see Hockley, Dunlop and Davies, 1715-1717.

Significantly, the available evidence suggests that the factors prompting a request for active euthanasia are not intractable physical pain but unbearable or senseless suffering.²⁰⁷ As a matter of personal dignity, autonomy, and self-determination, patients in such circumstances should have the liberty to choose death. Whilst palliative care clearly constitutes a vital part of the overall care for terminal patients and may, if made widely available, help to reduce the need for active voluntary euthanasia, it can by no means obviate the need for it entirely. Knowledge that the possibility of active voluntary euthanasia is available may offer to patients the opportunity to live their final days in peace.²⁰⁸

Quantitative Need for Euthanasia Not Large

Another argument raised by the opponents of euthanasia is that legalisation is unnecessary since there is no great demand for active euthanasia in practice.²⁰⁹ Although there are enormous difficulties involved in accurately quantifying the extent of demand for active voluntary euthanasia, evidence was presented in chapter II that some patients do request active euthanasia, notwithstanding the present illegality of the practice,²¹⁰ and if it were to be legalised, more patients would undoubtedly articulate such requests. In the light of the available information, it is reasonable to assume that if active voluntary euthanasia were legalised it would be an option sought by only a small minority of patients.²¹¹ Even so, that arguably already constitutes sufficient justification for legalising the practice.²¹² The arguments advanced in support of active voluntary euthanasia are based on fundamental principles and do not rely for their validity on claims regarding the extent of demand for the practice.

Adequacy of Present Position

A rather interesting argument advanced by some opponents is that legislation covering active voluntary euthanasia is unnecessary since present law and practice adequately deal with the situation and any legislative change would open the floodgates to unnecessary deaths.²¹³

Essentially this is an argument for retaining the status quo, but on closer examination this argument discloses the blatant hypocrisy of many of the opponents. It seems that they are willing to acknowledge that doctors may, in appropriate cases, administer active euthanasia without attracting legal sanction, yet are unwilling to condone any change in the law which legalises this practice. This puts doctors in an impossible situation; the conflicting message that they are given is that although

²⁰⁷ Sneiderman, B. 'Euthanasia in the Netherlands: A Model for Canada?' (1992) 8 *Humane Med.* 104, 108. See, for example, the findings of the Rummelink survey in the Netherlands (discussed in chapter VIII, 378-385) which found that for a majority of patients, loss of dignity was the principal reason behind the request and in only a small minority of case was pain the sole reason.

²⁰⁸ R. Finley 'Euthanasia Debate' (letter) (1991) 323 *New Eng.J.Med* 1771.

²⁰⁹ Kamisar, 1011.

²¹⁰ See chapter II, 114-116.

²¹¹ Some guide as to the demand for active voluntary euthanasia if it were legalised can be gleaned from the Netherlands where the practice, although not actually legal, has received some official support. The Rummelink survey (discussed in chapter VIII, 378-385) found that there are approximately 9,000 explicit requests for active euthanasia or assisted suicide each year in the Netherlands which has a population of approximately 14 million and an annual total of approximately 130,000 deaths.

²¹² See also Williams, 'Euthanasia Legislation: A Rejoinder to Non-Religious Objections', 156, 164.

²¹³ Kamisar, 1041-1042.

active voluntary euthanasia is unlawful, the law may turn a blind eye to its administration in practice.²¹⁴ Whilst it is unlikely that a doctor would be prosecuted for murder it is undesirable that doctors should be exposed to the risk of criminal liability. The recent conviction of Dr Cox in the United Kingdom for the attempted murder of his patient has brought into sharp focus the legal vulnerability of doctors who respond to a patient's request for active euthanasia.²¹⁵ Moreover, the present practice of active euthanasia is necessarily informal and covert, and is, therefore, more likely to be discriminatory and subject to abuse. If, as a society, we have reached a situation where we accept the practice of active voluntary euthanasia in appropriate cases but wish doctors to avoid prosecution, it would be much more satisfactory to formalise the situation by legalising active voluntary euthanasia in carefully regulated circumstances. As suggested in the preceding chapter, there are powerful arguments in favour of closing the gap between the law on the books and the law in practice.²¹⁶

The Patient Can Always Commit Suicide

Another basis on which some opponents of euthanasia argue that legislative change is unnecessary is that patients who are serious about wanting death always have the option of committing suicide.²¹⁷ Some opponents regard suicide as preferable to active voluntary euthanasia since it removes doubt as to the voluntariness of the act and avoids the problems associated with third party involvement.

Committing suicide is by no means an easy thing to do. Information about the means of committing suicide may be difficult to obtain²¹⁸ and suicide attempts without medical information and/or help are often messy, undignified and ultimately unsuccessful. In many instances, those patients who would be likely to seek active voluntary euthanasia (i.e. patients who have reached an advanced stage of terminal illness) are no longer in a position to take their own lives. They are often immobilised by their condition and simply do not have the means available to commit suicide without the co-operation of others.²¹⁹ Moreover, some persons may find the concept of suicide repugnant, yet would willingly avail themselves of the option of active voluntary euthanasia administered by a doctor. Further, it could be argued that if suicide is to be the only option available to patients, it would tend to encourage persons who are aware of their hopeless condition to act while they are still physically able to do so, thereby possibly depriving them of extra time which they may have enjoyed had medically administered active voluntary euthanasia been available.²²⁰

²¹⁴ Nowell-Smith, 86; Williams, 'Euthanasia Legislation: A Rejoinder to Non-Religious Objections', 156, 157-158; Flew, 40, 45-46. For criticism of this position see also the Institute of Medical Ethics, Working Party Discussion Paper, 611.

²¹⁵ For further discussion of this case, see chapter IV, 126-127.

²¹⁶ See chapter IV, 146-150.

²¹⁷ For example, Kamisar, 1011; Grisez, 'Suicide and Euthanasia', 742, 803.

²¹⁸ In the United States a number of so-called 'suicide manuals' have been published by the Hemlock Society, (a pro-euthanasia advocacy group); D. Humphry, *Let Me Die Before I Wake* (5th ed. 1987); D. Humphry, *Final Exit* (1991). This latter book, which is quite explicit in setting out drug dosages and techniques on how to commit suicide, was initially banned for distribution in Australia by the Film and Literature Board, but following considerable criticism of this decision the ban has been lifted and the book will be available to persons of 18 years and over as a restricted publication.

²¹⁹ Williams, 'Euthanasia Legislation: A Rejoinder to Non-Religious Objections', 164-165; Moore, 336.

²²⁰ See also J.C Fletcher, 307, 318.

Final Days

A further argument, possibly with religious overtones, is that one can never know what the final days of life for a dying patient will hold and that by allowing active voluntary euthanasia, we may foreclose the possibility of some profound good such as reconciliation, reaffirmation or realisation.²²¹

Undoubtedly for some patients, their final days in the face of impending death may yield unexpected and invaluable experiences. However, this is not a valid argument for denying the individual the liberty to choose an earlier death. It would be unjustifiably paternalistic to insist that patients must endure a prolonged dying in the hope that this will be a rewarding experience. The wishes of a patient who has decision-making capacity ought to be respected, even though this may result in lost spiritual or emotional opportunities for him or her.

Effect on the Doctor/Patient Relationship

A further objection which is frequently raised by opponents to euthanasia is that any change to the law permitting doctors to administer active voluntary euthanasia, would have serious implications for the relationship between doctor and patient.²²² This argument is often supported with claims that the doctors are opposed to active voluntary euthanasia and do not wish to become involved in its practice.²²³

Opponents argue that the doctors' traditional role in the community, based on the Hippocratic Oath,²²⁴ has been that of healer, trusted with the responsibility of saving and prolonging life and that to cast doctors in the role of administering active euthanasia would undermine and compromise the objectives of the medical profession and destroy the trust and confidence that is essential to the success of the doctor/patient relationship.²²⁵ Doctors would be viewed by their patients as killers instead of healers, and patients - in any event a vulnerable group - would feel threatened because of their doctor's possible participation in active euthanasia. Thus, opponents argue, the prohibition on active euthanasia must remain in order to preserve the doctor/patient relationship and to ensure that patients can at all times feel that their doctor will act as the guardian of life.²²⁶ Apart from the need to protect the doctor/patient relationship, concerns have also been raised regarding the possible psychological consequences to doctors if they participate in the practice of active voluntary euthanasia.²²⁷ For

²²¹ Gillett, 67.

²²² Pollard, *Euthanasia*, 73-75; Trowell, 128-131; St. John Stevas, 275; Church Assembly Board for Social Responsibility, *On Dying Well*, 59; Rice, 58.

²²³ For example, St. John Stevas, 275.

²²⁴ *Inter alia*, the Oath provides; 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel'. For a modern translation of the Hippocratic Oath see L. Edelstein, *The Hippocratic Oath* (1943).

²²⁵ For example, Capron, 55; Kass, 35; Church Assembly Board for Social Responsibility, *On Dying Well*, 59; Keyserlingk, *Sanctity of life or Quality of Life*, 128; President's Commission Report, 79; B.M.A. Working Party Report, *Euthanasia*, 18-20.

²²⁶ Trowell, 130-131.

²²⁷ For example, R. Misbin, 'Physicians' Aid-in-Dying' (1991) 325 *New Eng.J.Med.* 1307, 1309. Note also D. Schiedermayer, R. Shapiro and J. Puma, 'Euthanasia' (letter) (1989) 321 *New Eng.J.Med.* 120.

example, fears have been expressed that to allow a doctor to kill a patient, even at the patient's request, is to desensitise the doctor to the value of human life.²²⁸

First of all it should be noted that the objection based on the potential damage to the doctor/patient relationship is not an absolute argument against the legalisation of active voluntary euthanasia; euthanasia need not necessarily be performed by the medical profession and it would be possible to frame legislation in such a way so that doctors are not involved.²²⁹ However, doctors are clearly the most appropriate group of persons to administer active voluntary euthanasia in view of their contact with and knowledge of the patient, and their medical expertise which is necessary to facilitate a painless and dignified death. Moreover, doctors practice under well-recognised codes of ethics and have the professional integrity and organisation to administer and monitor the implementation of active voluntary euthanasia.²³⁰ And whilst it is true that professional medical associations are overwhelmingly opposed to active voluntary euthanasia,²³¹ surveys indicate that a significant proportion of doctors would be willing to participate in the practice if it were legal.²³² Furthermore, as outlined above, there is evidence to suggest that some doctors already perform active euthanasia.²³³ As was argued earlier, if this is indeed the case, it would be preferable for the practice to be open and regulated.²³⁴ It is important, however, to emphasise that proper legislation would not impose upon doctors a duty to kill - it would simply allow a willing doctor to comply with the patient's request for active euthanasia without the fear of incurring criminal liability.²³⁵

Assuming then, that if active voluntary euthanasia were to be legalised, doctors would be the ones to administer it, consideration needs to be given to the substance of the opponents' argument that permitting doctors to perform active voluntary euthanasia would be contrary to the traditional role of the medical profession and would adversely effect the doctor/patient relationship.

Properly understood, the goals of medicine are to prolong and preserve life and cure disease, but at the same time, to relieve pain and suffering.²³⁶ These goals are potentially conflicting: the prolongation of life may prolong suffering, and conversely, in order to relieve pain and suffering, it may be

²²⁸ Misbin, 1309.

²²⁹ See also Flew, 44-45. Provision could, for example, be made for active euthanasia to be performed by friends or relatives of the patient, or by trained lay persons. One suggestion, which would avoid the involvement of ordinary medical practitioners, has been advanced by R. Crisp, 'A Good Death: Who Best to Bring It?' (1987) 1 *Bioethics* 74, 77-79 where he suggests that if active voluntary euthanasia were to be legalised it should become part of an area of medical specialisation in the care of the terminally ill.

²³⁰ See also Brock, 21; South Australian Voluntary Euthanasia Society, *Voluntary Euthanasia and the Medical Profession: An Invitation to Dialogue* (1990) 27.

²³¹ With the exception of the Doctors' Reform Society in Australia and the Royal Dutch Medical Association in the Netherlands.

²³² See Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia,' 625; Medical Practitioners Concerned with Assisted Dying, Media Release, 'South Australian Doctors Help Incurable Patients to Die' 28 July 1992; Center for Health Ethics and Policy Graduate School of Public Affairs, University of Colorado at Denver, *Withholding and Withdrawing Life-Sustaining Treatment* (1988) 15-16. For more detailed discussion see chapter VI, 265-266, 277, 282-283.

²³³ See chapter IV, 117-121.

²³⁴ See above, 191-192.

²³⁵ P. Key, 'Euthanasia: Law and Morality' (1989) 6 *Auckland U.L.Rev.* 224, 240.

²³⁶ E. Cassel, 'The Nature of Suffering and the Goals of Medicine' (1982) 306 *New Eng.J.Med.* 639.

necessary to shorten life.²³⁷ Importantly, it must be recognised that in some cases, life cannot be saved nor disease cured. In these circumstances, the doctor's role in alleviating suffering is of paramount importance and the administration of active euthanasia at the patient's request can be seen as a legitimate part of the doctor's role as health care professional; the principle of patient autonomy should be sufficient to override the imperative to save life while still honouring the doctor/patient relationship in continuing to relieve suffering.²³⁸ And whilst opponents frequently argue that the Hippocratic Oath prohibits doctors from acceding to patient's requests for active voluntary euthanasia, this objection has little force in contemporary society, where a literal interpretation of the Oath is of limited practical relevance.²³⁹

Further, it can be argued that legalisation of doctor administered active voluntary euthanasia would not necessarily have adverse effects on the doctor/patient relationship. If one has regard to the position in the Netherlands, where active voluntary euthanasia is now openly practiced, there does not appear to have been any erosion of the trust between patients and their doctors.²⁴⁰ In fact, for many people, the knowledge that their doctor could assist in administering active euthanasia at their request would have a positive effect, fostering greater confidence, and relieving anxiety about an agonising and undignified death.²⁴¹ Thus, contrary to the claims of opponents, the legalisation of doctor administered active voluntary euthanasia could have the effect of strengthening the doctor/patient relationship. Support for this view can be derived from public opinion polls which show overwhelming support for doctors being able to administer active voluntary euthanasia.²⁴² To suggest that doctors performing active voluntary euthanasia would be viewed as 'killers' ignores the fact that the legalisation of active euthanasia would be subject to stringent safeguards, requiring patient consent, and providing that any termination of life not in accordance with those requirements would remain unlawful and punishable as homicide.²⁴³ There is good reason to believe that the public's trust and confidence in the medical profession will not decrease if its members are sure that active euthanasia will not be administered

²³⁷ M. Parker, 32.

²³⁸ *Ibid.*

²³⁹ See R. Winton, *The Doctors' Oath* (1987) 9 where he points out that medical students in Australia are not required to recite the Hippocratic Oath when they graduate. Quite a number of commentators have cast doubt on the status of the Hippocratic Oath; some have suggested that even in its day, the Oath did not represent the views of the majority of doctors (e.g. D. Humphry and A. Wickett, *The Right to Die* (1986) 327; R. Devettere, 'Reconceptualising the Euthanasia Debate' (1989) 17 *Law, Med. & Health Care* 145, 147; others have suggested that notwithstanding the terms of the Oath, the Hippocratic tradition was not opposed to active voluntary euthanasia; e.g. P. Carrick, *Medical Ethics in Antiquity* (1985) 154-159.

Quite apart from the issue of active euthanasia, evidence of the irrelevance of the Hippocratic Oath for practical purposes can be found with regard to the abortion issue; although prohibited under the Oath, abortion is a fairly common medical practice.

²⁴⁰ See the Institute of Medical Ethics, Working Party Discussion Paper, 611 and chapter VIII, 391-392 dealing with the position in the Netherlands.

²⁴¹ H. Cohen, 'Euthanasia as a Way of Life' (1991) 43 *Hemlock Q.* 7, 7-8; Russell, 223; Kuhse, 'The Alleged Peril of Active Voluntary Euthanasia: A Reply to Alexander Morgan Capron', 63-64; Institute of Medical Ethics, Working Party Discussion Paper, 611.

²⁴² See chapter VI, 229-239.

²⁴³ See also J. Davies, 'Raping and Making Love are Different Concepts: So are Killing and Voluntary Euthanasia' (1988) 14 *J. Med. Ethics* 148, 148-149.

without their explicit request.²⁴⁴ Doctors are bound by strict codes of ethics and can be trusted to act responsibly if empowered to perform active voluntary euthanasia.

The final aspect to the opponents' objection to the involvement of doctors in the practice of active voluntary euthanasia based on the possible detrimental psychological effects on doctors can also be rejected. There is simply no evidence to support this argument and in fact the experience in the Netherlands suggests the contrary.²⁴⁵ Even if one were to accept the possibility of potential psychological damage if doctors become involved in the practice of death, the risk of such damage would be minimised by ensuring that doctors' participation in active euthanasia at the patient's request would be entirely voluntary. It must also be borne in mind that active euthanasia would be an option sought by only a small minority of patients so the occasions that a doctor would be involved in its performance would be few and far between. In any event, the concept of active voluntary euthanasia cannot be judged in isolation. It has been argued earlier in this thesis that doctors are already involved in conduct which hastens death in the form of omissions to provide treatment and the administration of some pain-relieving drugs.²⁴⁶ In these circumstances, it is difficult to allege that the voluntary participation of a doctor in active euthanasia at the request of a patient would be likely to have a detrimental psychological effect on doctors. Moreover, it could be argued that there are also problems in retaining the status quo; doctors may become desensitised to human suffering if they feel they are denied by law the means to alleviate that suffering.²⁴⁷ For the foregoing reasons, the objections of opponents to doctors' participation in active voluntary euthanasia are largely without foundation.

Legalisation Would Discourage Medical Research and Developments in Palliative Care

A further argument which has been advanced against the legalisation of active voluntary euthanasia is that it would discourage the search for new cures and progress in palliative care.²⁴⁸ Opponents argue that the prohibition on active euthanasia has been an important impetus in the development of humane terminal care and research for cures for terminal conditions. If we now permit active voluntary euthanasia, we will be jeopardising future developments in these areas to the detriment of the majority of patients.

Few would wish to disagree with the proposition that research efforts should be encouraged and that every attempt should be made to devise more humane forms of terminal care; indeed this may help to reduce the number of patients who would request active euthanasia as a solution to their situation. However, it cannot be assumed, as the euthanasia opponents appear to have done, that legalisation of

²⁴⁴ See also Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands', 519; Kuhse, 'The Alleged Peril of Active Voluntary Euthanasia: A Reply to Alexander Morgan Capron', 64.

²⁴⁵ See chapter VIII, 391-392.

²⁴⁶ See chapter IV, 121-122. For analysis of these practices, see chapter IV, 150-175.

²⁴⁷ Misbin, 1309.

²⁴⁸ See, for example, Potts, 504-505; S. Wolf, 'Holding the Line on Euthanasia' (1989) 19 *Hastings Center* R. 13; R. Twycross, 'Debate: Euthanasia - A Physician's Viewpoint' (1982) 8 *J. Med. Ethics* 86, 91; J.C. Fletcher, 297-321; Grisez and Boyle, 151.

active voluntary euthanasia would necessarily have the effect of discouraging medical research and progress in palliative care. Since active voluntary euthanasia would more than likely be an option only sought by a small minority, justification would remain for continuing research and improvements in terminal care for the great majority of patients. It is, in any event, misguided to regard active voluntary euthanasia as in any way competing with medical research and developments. Rather, what opponents wish to achieve is to expand the options available to patients, by offering active voluntary euthanasia alongside other forms of care and treatment.²⁴⁹

Evaluation of the Case For and Against Active Voluntary Euthanasia

In the preceding part, attention has focused on the objections that have most frequently been raised against the legalisation of active voluntary euthanasia. In assessing these arguments, it must be emphasised that we are dealing with the issue of legalisation of active voluntary euthanasia. So, whilst many of the arguments may be perfectly valid objections to non-voluntary or involuntary euthanasia, the crucial distinction between voluntary euthanasia on the one hand, and involuntary or non-voluntary euthanasia on the other, must be firmly borne in mind.

The basis for opposition to legalisation of active voluntary euthanasia has come from a variety of sources, including religious, moral and philosophical objections, but the most serious challenge to the pro-legalisation case undoubtedly stems from objections based on practical arguments. There is, in fact, a significant area of common ground in the euthanasia debate in that many commentators would agree that legalisation of active voluntary euthanasia would give rise to the risk of abuse, mistake and other undesirable consequences. However, a fundamental difference of opinion exists as to the appropriate response in these circumstances. Opponents vigorously argue that legalisation, even under strict conditions, would create unacceptable risks and that the benefits which would be gained would be far outweighed by the dangers to society.²⁵⁰ Thus, they argue, the risks and dangers are too great to warrant a change to the existing law. Proponents, on the other hand, emphasise the importance of patient autonomy. They contend that the risks and dangers associated with legalisation do not justify an absolute prohibition of active voluntary euthanasia and can be adequately dealt with by appropriate regulation and the imposition of rigorous safeguards. Further, they argue that the criminal law should not intervene in the exercise of individual liberty unless there are compelling social interests requiring it to do so.²⁵¹

²⁴⁹ Glover, 187-188.

²⁵⁰ For example, Kamisar, 976; Law Reform Commission of Canada Working Paper on Euthanasia, 46-48.

²⁵¹ For example, Morris, 254.

PART III

The Legal Philosophers' Debate: The Role of the Criminal Law

The euthanasia debate gives rise to fundamental questions about the rights and interests of individuals weighed against the values and interests of society as a whole. The aim of this part is to examine the role of the criminal law and ascertain the circumstances in which State intervention in individual autonomy is justified. Specific consideration will then be given to the proper scope of the criminal law with regard to active voluntary euthanasia.

The Libertarian Premise: The Prevention of Harm

Of the competing views regarding the appropriate basis for criminal law intervention,²⁵² the most convincing argument is the libertarian premise that individuals should be free to do as they please, provided that their conduct does not cause harm to others; in short, the 'harm principle'.²⁵³ The classic exposition of this view is by John Stuart Mill, in his now famous *On Liberty*,²⁵⁴ where he wrote that:

The only purpose for which power can rightfully be exercised over any member of a civilised community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or to forbear because it will be better for him to do so, because it will make him happier, because in the opinion of others, to do so would be wise or even right.²⁵⁵

According to this view, the principal role of the criminal law is to protect society and its members against harm and to punish behaviour which threatens or harms public interests. This involves protection, not only from physical injury, but also the protection of fundamental social values and interests.²⁵⁶ Individual freedom is qualified only by the restraint necessary for the protection of the bodily integrity and freedom of others. Prevention of self-caused harm is not a valid ground for intervention with a person's autonomous choices. As was seen in an earlier chapter the common law has traditionally accorded the highest value to the preservation and protection of human life.²⁵⁷ The common law tradition, as reflected in the criminal law sanctions, regards human life as sacred and inalienable and prohibits anyone from licensing their own self-destruction. The prohibition of

²⁵² For discussion of some of the possible justifications for State intervention in the affairs of the individual, see, for example, J. Feinberg, *The Moral Limits of the Criminal Law*, a four volume series comprised of Vol. I *Harm to Others* (1984); Vol. II *Offense to Others* (1985); Vol III *Harm to Self* (1986); and Vol. IV *Harmless Wrongdoing* (1988).

²⁵³ For detailed analysis of the meaning of 'harm', see Feinberg, *Harm to Others*, 31-64.

²⁵⁴ (2nd ed., 1859).

²⁵⁵ 72.

²⁵⁶ Canadian Law Reform Commission, *Our Criminal Law* (1976) 16.

²⁵⁷ See chapter I, 15-16, 17-18.

homicide constitutes a fundamental component of the criminal law's protection of human life. This prohibition is obviously necessary for the protection of society and its members, since killing is normally a harm, violating the right to life of the person killed. Thus, a clear rule against active killing is entirely justified.

The question arises as to whether a merciful killing at the patient's request should be treated as any other homicide. Although killing will usually constitute a harm, this is not always the case. Killing of a person is only wrongful and constitutes a harm where it deprives a person of their right to life.²⁵⁸ Where, however, a person has a rational interest in dying and has expressed a clear wish to do so, the killing of that person violates no rights and therefore, does not constitute a 'harm' in the accepted sense.²⁵⁹ In the absence of harm to any individual, there is arguably no need for the criminal law prohibition of murder to apply. Furthermore, even if it were accepted as a general proposition that the State has a legitimate interest in the lives of its citizens such that it may prevent a healthy person from taking his or her life,²⁶⁰ in the circumstances where a person is terminally or incurably ill and expresses a wish to die, the State can claim no compelling social interests justifying interference with the individual's liberty to choose a quick and painless death.²⁶¹ Indeed, in the case of active voluntary euthanasia, it is difficult to see how acceding to the request of a terminal or incurable patient for a release from suffering can in any practical sense endanger society. If we are to respect the individual's right to liberty, we must allow him or her to seek an earlier death with the assistance of others.²⁶²

Opponents will, once again, seek to rely on the 'wedge argument' as a basis of justifying the maintenance of the existing prohibition on active voluntary euthanasia, arguing that the present law provides a valuable barrier against unlawful killing which we must be careful to preserve. Consideration has already been given to the counter-arguments to the wedge objection and no attempt will be made here to retrace that ground. What may be observed, however, for the purposes of the present analysis, is the inconsistency of the present law which permits human life to be deliberately taken in some circumstances without criminal consequences, yet categorically prohibits the taking of life at the request of a fully informed patient who has decision-making capacity. So, for example, in cases of war, capital punishment and self-defence the criminal law has made some concession to the sanctity of life principle and accepts that there may be good reason for the intentional termination of life. Some important public interest seems to have been recognised sufficient to justify these cases of killing, despite the general presumption of the law against the taking of life.²⁶³ Yet, according to

²⁵⁸ B. Brody, 'A Non-Consequentialist Argument for Active Euthanasia' in B. Brody and T. Engelhardt, *Bioethics* (1987) 161-165; Richards, 358-359; Kohl, 'Euthanasia and the Right to Life', 80.

²⁵⁹ Feinberg, *Harm to Others*, 116; R. Young, 'What is So Wrong with Killing People' (1979) 54 *Phil.* 515, 518, 524.

²⁶⁰ Any such claim is objectionable in so far that it implies that citizens have a duty to live and contribute to society. For further criticism, see also T. Engelhardt and M. Malloy, 'Suicide and Assisting Suicide: A Critique of Legal Sanctions' (1982) 36 *Sw.L.J.* 1003, 1009-1010; Richards, 376-378.

²⁶¹ Williams, 'Euthanasia Legislation: A Rejoinder to the Non-Religious Objections', 157; Moore, 330; Small, 200; Arras, 293.

²⁶² Note also Rachels, *The End of Life*, 181-182 where he argues that Mill's principle applies not only to acts which are entirely self-regarding (e.g. suicide) but also to individuals who voluntarily agree to act together; this is still a private affair and no one else's interests need be involved.

²⁶³ Grisez and Boyle, 190.

current criminal law principles, the consent of the patient is not regarded as sufficient justification to absolve another person from criminal liability for assisting the patient to die.

The Present Limits of Consent

In the earlier analysis of the criminal law in chapters I and II, attention was drawn to the very significant limits that are placed on consent for the purposes of the criminal law.²⁶⁴ It was shown that on the basis of established principles, one cannot licence the infliction of death on oneself by another.²⁶⁵ Indeed, the consent of the victim is, strictly speaking, irrelevant to the issue of liability for homicide. The question arises, however, why an individual should not be able to validly dispose of his or her right to bodily integrity by consenting to be killed, provided that no harm is thereby caused to others? In other contexts the consent of the individual is all important, for example with regard to medical treatment with the consequence that the administration of treatment without the consent of a patient who has decision-making capacity would generally be unlawful. It could, accordingly, be argued that an individual should have the same right to consent or not to consent to active voluntary euthanasia and consent ought not be vitiated on questionable public policy grounds.²⁶⁶

It must be understood that what is being claimed here is not a general right that all individuals be free to lawfully consent to their own death. Indeed, it is acknowledged that the State has a direct interest in maintaining the lives of healthy and productive citizens and maintaining social order and that the introduction of a general right to consent to one's death could undermine these legitimate State interests. Rather, what is being claimed is a more limited entitlement for terminal and incurable patients that they may give a legally effective consent to a doctor to bring about their death. In these circumstances, the State does not have a sufficient interest in the timing and manner of the patient's death to justify negating the patient's consent.

Relationship between Law and Morality

It was suggested earlier that the principle role of the criminal law is to protect society and its members against harm and to punish behaviour which threatens or harms public interests.²⁶⁷ Another issue which must be addressed is the relationship between law and morality, and what bearing this has upon the question of legalisation of active voluntary euthanasia. Is active voluntary euthanasia immoral, and further, is the answer to this question determinative of whether it should be subject to criminal sanction?

There has been a longstanding debate about the proper role of the criminal law, and more particularly, whether the criminal law should be used to attempt to enforce morality, even though immorality will

²⁶⁴ See chapter I, 16-18, and chapter II, 70-81.

²⁶⁵ G. Williams, 'Consent and Public Policy' (1962) *Crim.L.Rev.* 74 (Part 1), 154 (Part 2).

²⁶⁶ Cf. G. Fletcher, *Rethinking the Criminal Law* (1978) 770-771 where he seeks to explain why autonomy gives way to competing social values in these circumstances.

²⁶⁷ See above, 222.

cause no tangible harm to others.²⁶⁸ The leading exponent of the view that the criminal law does have a role in enforcing morality has been Lord Devlin in his much acclaimed work, *The Enforcement of Morals*.²⁶⁹ Devlin's thesis is that the law exists for the protection of society, not merely for the benefit of the individual, and in order to discharge its function, the law must protect the community of ideas, political and moral, without which no society can exist.²⁷⁰ In support of his thesis, Devlin seeks to demonstrate that the criminal law is in fact based upon moral principles and to illustrate this proposition, he refers to the attitude which the criminal law adopts towards consent. He argues the reason that an individual cannot consent to an offence against himself is because it is an offence against society, in that it threatens one of the great moral principles upon which society is based - the sanctity of human life. Thus, he concludes, there is only one explanation of what has hitherto been accepted as the basis of the criminal law; that there are certain standards of behaviour or moral principles which society requires to be observed, the breach of which is an offence not merely against the person who is injured but against society as a whole.²⁷¹

However, many commentators disagree with the proposition put forward by Devlin that the enforcement of a common morality is within the proper scope of the criminal law.²⁷² The primary objection to Devlin's moral theory is that the legal enforcement of morals will seriously impinge upon individual freedom and self-determination. The view is widely held that there are some areas of private morality and individual conscience which simply ought not to be subject to legal sanction. With particular reference to Devlin's reasoning regarding the irrelevance of consent, it has been argued that the rules excluding the victim's consent as a defence to criminal charges do not necessarily support his contention that the function of the law is to enforce moral principles and instead may perfectly well be explained as a piece of paternalism, designed to protect individuals against themselves.²⁷³

Even if one disagrees with Devlin's principal thesis, one has to recognise that morality is not completely irrelevant to the criminal law. It seems obvious that some relationship between law and morality exists, in that much of what is criminal conduct will also incur the moral condemnation of the community, and conversely, the law draws its strength from the common morality. There can, however, be no one for one correspondence;²⁷⁴ the fact that something is immoral does not necessarily mean that it should consequently be unlawful, and conversely, whether or not something is lawful is not of itself determinative of the morality of that conduct.

²⁶⁸ For the principal contributors to the debate, see the Report of the Committee on Homosexual Offences and Prostitution (1957) Cmnd. 247 (hereafter referred to as the Wolfenden Report); Mill, (*On Liberty*); P. Devlin, *The Enforcement of Morals* (1965); H. Hart, *Law, Liberty and Morality* (1962). Note also Lord Hailsham, 'The Law, Politics and Morality' (1988) *Denning L.J.* 59.

²⁶⁹ (1965).

²⁷⁰ *Id.* 7-25.

²⁷¹ *Id.* 6-7.

²⁷² For example, the Wolfenden Report and Hart.

²⁷³ Hart, 30-34.

²⁷⁴ Hailsham, 60-61.

In the light of the foregoing analysis, we are now in a position to consider the issue of active voluntary euthanasia and the proper role of the criminal law in this area. Is active voluntary euthanasia immoral? The position taken in this thesis is that it is not, and that would certainly be the view of most of proponents of active voluntary euthanasia.²⁷⁵ However, in our pluralistic society, there is no community consensus regarding the morality of active voluntary euthanasia. But, the significant point is that once one accepts that there is no one for one correspondence between law and morality, it becomes unnecessary to pronounce decisively on the morality of active voluntary euthanasia. Thus, even if active voluntary euthanasia is immoral, that does not in itself constitute sufficient justification for maintaining the existing legal prohibition of the practice.²⁷⁶ By the same token, it is accepted that evidence of the morality of active voluntary euthanasia will not of itself be a decisive argument for its legalisation. Indeed, as we have seen, there are many opponents who argue that although active voluntary euthanasia may be moral in isolated cases, it ought nonetheless be prohibited.²⁷⁷ However, the practical arguments against legalisation have already been countered and in the absence of convincing evidence of likely harm to others resulting from a patient's choice to opt for an earlier death, the question of active euthanasia is essentially a matter of private choice which should be left to the individual patient in the exercise of his or her self-determination.

Furthermore, in assessing the appropriate relationship between law and morality, it should not be overlooked that it is possible that the enforcement of morality may itself lead to harm, far in excess of any possible harm that the prohibited practices themselves may entail. In the context of the law's continuing prohibition of active voluntary euthanasia this is a very real possibility. The prohibition is aimed at protecting the sanctity of life, but denying the patient the choice of an earlier death may violate the patient's dignity and self-determination and cause unnecessary suffering. Thus, in any analysis of the role of the law and the relationship between law and morality, one cannot ignore the costs involved in invoking the criminal law.

Relationship between Law and Public Opinion

Related to the foregoing discussion about law and morality is the issue of public opinion and the extent to which the law should reflect the wishes of the community. This is a relevant issue in the euthanasia debate, in view of growing public support for the legalisation of active voluntary euthanasia.²⁷⁸

The appropriate relationship between the law and public opinion has long been a matter for dispute. There is, for example, debate as to whether the law ought to follow behind public opinion, so that it can count on the support of the community as a whole or whether its role is to lead or fortify public

²⁷⁵ As Kohl notes, (*Beneficent Euthanasia*, xvi) it is possible to take the view that active voluntary euthanasia is morally wrong but should nevertheless be legalised. He points out, however, that this is not widely argued for in the literature.

²⁷⁶ Kohl, *Beneficent Euthanasia*; Flew, 40-41.

²⁷⁷ See above, 201.

²⁷⁸ See above, 195.

opinion.²⁷⁹ From the outset it should be acknowledged that the mere fact that there is public support for something cannot be taken as evidence that it ought be legalised. The relevance of public opinion must be more carefully justified than crude reliance on support in numbers.

While the criminal law obviously fulfils a number of roles, it has been argued in this thesis that its primary role is to protect society and its members from harm. This protective function is complemented by the criminal law's educative role, seeking to encourage law-abiding behaviour, and punishing those who threaten or harm public interests. Because of the criminal law's role in primarily protecting, and also educating the community, public support for the legalisation of active voluntary euthanasia can never, of itself, be sufficient justification for reform of the law. Public opinion may quite possibly be misguided or misinformed, or may have failed to take into account the full implications of legalisation. Before the case for reform is made out, it must be shown that the consequences of legalisation of active voluntary euthanasia have been addressed, and that no harm is likely to result to society or its members if the practice is legalised. Within these confines, public opinion should have a role in shaping the law, indicating, as it does, prevailing morality and the needs of the community. After all, ultimately, the law must serve the community and it must, therefore, be responsive to real social needs. It is widely recognised that if a law is markedly out of tune with public opinion it will quickly fall into disrepute.²⁸⁰ Thus, while evidence of community support for legalisation of active voluntary euthanasia is not of itself decisive, it is undoubtedly a relevant factor in determining the appropriateness of legalisation and in the chapter which follows, evidence will be provided of growing public support for the legalisation of active voluntary euthanasia.²⁸¹

In the preceding analysis an attempt has been made to demonstrate that active voluntary euthanasia differs significantly from other proscribed forms of killing and that in light of these differences, the present criminalisation of active voluntary euthanasia is beyond the proper scope of the criminal law. On libertarian principles, it has been argued that the State may only impose criminal sanctions in respect of conduct which is likely to cause serious harm to others. As there is no evidence that legalisation of active voluntary euthanasia would be likely to cause harm, retention of the existing prohibition cannot be justified.

The present law which prohibits active voluntary euthanasia is a violation of the individual's liberty and self-determination. The choice whether to live or die is essentially a private choice, and individuals should be permitted to live their lives according to their own life choices, free of coercion or paternalistic interference.²⁸² The liberty of the individual is paramount and must be preserved to the extent that it does not constitute a danger to society. The optimum way of maximising individual freedom with regard to active voluntary euthanasia, but at same time, ensuring protection of society and its members, is through the creation of a carefully defined exception to the general prohibition

²⁷⁹ The Wolfenden Report, para. 16.

²⁸⁰ *Ibid.*

²⁸¹ See chapter VI, 229-239.

²⁸² See also Arras, 292.

against killing. Recognition of such an exception is not inconsistent with the fundamental belief that human life has value and must be protected wherever possible. Indeed the criminal law's prohibition of murder will continue to protect the right to life of all patients who choose not to avail themselves of active voluntary euthanasia. Further, removal of the present prohibition would tend to promote justice and equity in that the opportunity to seek active assistance in dying would become openly available to all and the practice of active voluntary euthanasia would be subject to rigorous safeguards to protect against abuse.

Conclusion

As noted at the outset of this chapter, differences of opinion will always exist as to whether or not active voluntary euthanasia ought to be legalised. In the final analysis, the objections raised by the opponents are not sufficiently compelling to undermine the strong *prima facie* case which has been established for legalisation of active voluntary euthanasia. The practical concerns which have been raised about the effects of legalisation do not warrant a blanket prohibition and can be met by the implementation of appropriate regulations and safeguards. Further, having regard to the proper scope of the criminal law, it has been shown that there are no pressing social interests which demand retention of the criminal law prohibition. In our pluriform society, the most appropriate course to maximise individual freedom and self-determination is to remove the present legal prohibition so that all individuals will be free to live according to their own beliefs.²⁸³

Thus, it is submitted, active voluntary euthanasia is acceptable in principle, and re-evaluation of the criminal law prohibition is required. However, the practical objections which have been raised must be given serious consideration in any process of reform. The challenge which lies ahead is to formulate a legislative proposal which reduces the potential risks to an acceptable level, without interfering too severely with individual autonomy and self-determination.

²⁸³ See also Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands', 518; Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands', 205.

CHAPTER VI

THE CHANGING CLIMATE FOR REFORM

Introduction

The object of this chapter is to examine the changing climate for reform with regard to active voluntary euthanasia. This involves consideration of a number of related issues: (i) public opinion which appears to be increasingly in support of the legalisation of active voluntary euthanasia performed by doctors for terminally ill or incurable patients; (ii) the emergence of voluntary euthanasia organisations campaigning for the legalisation of active voluntary euthanasia; and (iii) developments within the medical profession indicating growing support for the concept of active voluntary euthanasia. Although these areas of change are very much interrelated, for the purposes of exposition, it will be necessary to deal with them separately. This chapter is accordingly divided into three parts: part I dealing with opinion polls, part II dealing with the voluntary euthanasia movement, and part III tracing changes within the medical profession. Whilst attention will primarily be focussed on changes in Australia, consideration will also be given to relevant developments in New Zealand, the United Kingdom, the United States and Canada. (The situation in the Netherlands will be dealt with separately in a later chapter.¹)

PART I

Public Opinion

Opinion Polls

Although there have, over time, been some fluctuations in public opinion on the issue of active voluntary euthanasia, opinion polls indicate growing public support in Australia and the other jurisdictions under consideration in favour of its legalisation.²

Australia

Since the early 1960s, opinion polls have been conducted regularly in Australia by the Morgan Research Centre to gauge the attitude of Australians to active voluntary euthanasia.³ Having the same

¹ See chapter VIII.

² S. Waller, 'Trends in Public Acceptance of Euthanasia Worldwide' (1986) 1 *Euthanasia Rev.* 33.

³ Morgan Gallup Polls have been conducted in Australia in 1962, 1978, 1983, 1986, 1987, 1989, 1990 and 1991 dealing with both passive and active euthanasia. There have been other polls conducted in

poll conducted over a long period of time by a reputable research organisation enhances the significance of the poll results which can be taken as a fairly accurate guide as to Australian public opinion on the issue of active voluntary euthanasia over this period. Those surveyed in this series of polls were asked: 'If a hopelessly ill patient, in great pain with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose, or not?' Whilst there has been some vacillation in public attitudes over time,⁴ the results of the Morgan Gallup Polls over the past two decades reveals an increase in public support in Australia for allowing a doctor to give a patient a lethal dose at the patient's request. (See Table A)

Table A

| | For | Against | Undecided |
|------|-----|---------|-----------|
| 1962 | 47% | 39% | 14% |
| 1978 | 67% | 22% | 11% |
| 1983 | 67% | 21% | 12% |
| 1986 | 66% | 21% | 13% |
| 1987 | 75% | 18% | 7% |
| 1989 | 71% | 20% | 9% |
| 1990 | 77% | 17% | 6% |
| 1991 | 74% | 20% | 7% |
| 1992 | 76% | 18% | 6% |

The most recent Morgan Gallup Poll, conducted in 1992, indicates that 76% of those surveyed were in favour of active voluntary euthanasia, with only 18% against and 6% undecided.⁵ This represents a significant increase from the 1962 Gallup Poll results according to which 47% of those surveyed were in favour of active voluntary euthanasia, 39% against and 14% undecided: a 29% increase in public acceptance of active voluntary euthanasia over a 30 year period. Not only has there been a distinct increase in levels of support, with a corresponding decline in those opposed to active voluntary euthanasia, but the proportion of respondents who are undecided has decreased substantially, (from 14% in 1962 to 6% in 1992), suggesting that more people have made up their minds on the issue.

The results do not reveal any consistent trends with regard to federal voting intention or with regard to the sex of those polled, though in the more recent polls, there appears to be evidence of greater support for active voluntary euthanasia amongst men than women.⁶ Analysis of the results on the basis of the age of the respondents indicates that the numbers in favour of active voluntary euthanasia were greater in the younger age groups, and older people were least likely to favour a doctor being

Australia on the subject of euthanasia but differences in questions and sampling techniques makes comparison difficult and attention will be confined to the Morgan Gallup Polls.

⁴ There have been a number of down-turns in public support, for example, in the period 1987-1989 and 1990-1991.

⁵ Similar results have been obtained in New Zealand. The 1991 Morgan Gallup Poll was also conducted in New Zealand; 72% of respondents were in favour of allowing a doctor to give a lethal dose, 20% against and 7% undecided.

⁶ See, for example, the Morgan Gallup Poll results for 1987, 1989 and 1990.

allowed to administer a lethal dose.⁷ The religious affiliation of respondents is also a relevant factor in determining their attitudes to active voluntary euthanasia, although perhaps not as significant a factor as one might expect. There is evidence which suggests that regular church-goers are much less likely to support active voluntary euthanasia than non-regular churchgoers, agnostics or atheists.⁸ Of those who are religiously affiliated, Roman Catholics are less likely to support active voluntary euthanasia than are Anglicans or members of the Presbyterian or Uniting Church.⁹ Nevertheless, despite the Catholic Church's opposition to euthanasia, recent polls indicate that a significant majority of Catholic respondents are in favour of a doctor being allowed to give a patient a lethal dose.¹⁰

United Kingdom

In the United Kingdom, opinion polls on the subject of active voluntary euthanasia date back to the 1930s. During that decade, the issue of legalisation of active voluntary euthanasia had been brought to public attention through the activities of the newly established Voluntary Euthanasia Society in London and the concerted attempts at legislative reform made in 1936. According to a Gallup Poll conducted in 1938, 62% of those polled believed that 'those suffering from an incurable disease should be allowed the option, under proper medical safeguards, of voluntary death', compared to 22% who disagreed.¹¹ By 1950, however, when Gallup conducted the same poll, the support for active voluntary euthanasia had dropped to 55%, with 24% of those polled disagreeing with the proposition that incurable patients should have the option of a voluntary death.¹² Although attempts to explain this decline in support for active voluntary euthanasia are merely speculative, it is quite possibly attributable to the negative connotations of the concept of euthanasia following the experience in Nazi Germany.

Since 1950, public acceptance of active voluntary euthanasia has gradually been increasing in the United Kingdom, although survey results reveal some fluctuations in public attitudes.¹³ It is impossible to ascertain whether these fluctuations are attributable to a distinct shift in public opinion over a particular period, or whether they simply result from a difference in the survey question used.¹⁴

⁷ See, for example, the Morgan Gallup Poll results for 1986, 1987 and 1990.

⁸ 1982 Age Poll, *The Age* 15 Nov. 1982. Respondents were asked: 'If an adult has a terminal or chronic illness and wishes to end his or her life, should the doctor help such an adult to die if asked to do so, or refuse to help such an adult to die if asked to do so?' Whilst overall 69% of those surveyed were in favour of allowing a doctor to help a patient to die, analysis by religion revealed that only 43% of churchgoers were in support of such assistance (47% against) compared with 74% of non-regular churchgoers (18% against) and 82% of agnostics or atheists (12% against). See also the Morgan Gallup Poll results for 1991.

⁹ See, for example, the Morgan Gallup Poll conducted in Victoria in May 1986, commissioned by the Victorian Voluntary Euthanasia Society and discussed by the Parliament of Victoria Social Development Committee in its Second and Final Report, *Inquiry into Options for Dying with Dignity* (1987) 133-135. Of those who had responded yes to the question of whether a doctor should be able to assist a patient to die the religious break up was as follows; Catholic 66.3%, Anglican 80.3%, Presbyterian/Uniting 71.1%, other Christians 68.5%, no religion 82.9%.

¹⁰ See, for example, the Morgan Gallup Poll results for 1991.

¹¹ 16% undecided; see Waller, 42.

¹² 21% undecided; see Waller, 42.

¹³ Note, for example, the decline from 69% in 1976 to 62% in 1979 in the National Opinion Polls.

¹⁴ For example, although the 1976 and 1979 polls were both conducted by National Opinion Polls, a different question was used.

In a 1976 National Opinion Poll, responses were sought to the following question: 'Some people say that the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided they have previously requested such help in writing. Please tell me whether you agree or disagree with this?' Of those polled, 69% indicated their agreement with this statement, 17% disagreed and 14% were undecided. Another survey was conducted three years later, also by National Opinion Polls, but asking quite a different question. Respondents were asked: 'Do you agree that, if a patient is suffering from a distressing and incurable illness, a doctor should be allowed to supply that patient with the means to end his own life, if the patient wishes to?' Sixty-two percent of those surveyed agreed, 22% disagreed and 16% were undecided. Because of the difference in survey question used in the 1976 and the 1979 polls, little weight can be attached to any apparent trend arising from these results. Of greater statistical relevance are the 1985 and the 1989 surveys conducted by National Opinion Polls, where a question of identical wording was used to that in the 1976 National Opinion Poll. The results of these polls, when analysed in connection with the 1976 poll, provide some indication of changes in public attitudes on the subject of active voluntary euthanasia in the United Kingdom over this period. (See Table B) During the intervening 13 years since the 1976 survey, the proportion of the population in agreement with the statement had risen from 69% to 75%, a 6% increase for that period, with only 16% against. There was also a significant reduction in the category of 'don't knows', from 14% in 1976 down to 9% indicating that by 1989, more people had formed an opinion on the issue.

Table B

| | For | Against | Undecided |
|------|-----|---------|-----------|
| 1976 | 69% | 17% | 14% |
| 1985 | 72% | 21% | 8% |
| 1989 | 75% | 16% | 9% |

The results of the 1976, 1985 and 1989 National Opinion Polls do not show any statistically significant difference in terms of sex or economic class, but there is a definite age divergence, with younger respondents tending to be more in favour of active voluntary euthanasia than the older age groups. Religious affiliation is also clearly a significant factor. Although members of all the main religious denominations, (including Roman Catholics), show a majority in favour of active voluntary euthanasia, Roman Catholics are less likely to support active voluntary euthanasia than are members of the Church of England or atheists.¹⁵

Because of the lack of consistency in the United Kingdom in the assessment of public opinion on the subject of active voluntary euthanasia both in terms of the frequency of the polls and the survey

¹⁵ In the 1976 poll, 54% of Roman Catholics supported active voluntary euthanasia compared with 72% support from members of the Church of England, 71% support from Methodists and 77% support from members of the Church of Scotland. In the 1985 poll only 54% of Roman Catholics supported active voluntary euthanasia compared with 75% support from members of the Church of England, 72% of Methodists and 89% of atheists in favour of active voluntary euthanasia. By 1989, support from members of the Roman Catholic Church had increased to 68% as compared with 78% of members of the Church of England in favour and 86% of atheists.

questions used, some caution is required in analysing the available results. It can, nevertheless, be concluded, particularly having regard to the series of National Opinion Polls conducted in 1976, 1985 and 1989, that there is growing public support in the United Kingdom for active voluntary euthanasia.

United States

Numerous polls have been conducted in the United States by a number of research organisations over the past 40 or so years to assess public attitudes on the subject of active voluntary euthanasia.¹⁶ The principal research organisations to conduct opinion polls on this subject in the United States have been Gallup, (Gallup National Opinion Research Center) Roper, and Harris, each using their own survey question.¹⁷ Although there are some discrepancies in the results as between research organisations,¹⁸ quite possibly attributable to the different questions being asked of respondents,¹⁹ the overall results of the various polls indicate a substantial growth in acceptance of active voluntary euthanasia by the American public since the late 1940s. (See Table C)

Table C
Gallup Poll/National Opinion Research Centre

| | For | Against | Undecided |
|------|-----|---------|-----------|
| 1947 | 37% | 54% | 9% |
| 1950 | 36% | 54% | 10% |
| 1973 | 53% | 40% | 7% |
| 1982 | 61% | 34% | 5% |
| 1983 | 63% | 32% | 3% |
| 1990 | 65% | 31% | 4% |

¹⁶ For discussion of opinion poll results in the United States with regard to active voluntary euthanasia, see R. Russell, *Freedom to Die* (Revised ed., 1977) chapters 4-7, (and supplement to first edition, 387-389) D. Humphry and A. Wickett, *The Right to Die* (1986) 123-124; J. Ostheimer, 'The Polls: Changing Attitudes Towards Euthanasia' (1980) 44 *Public Opinion Q.* 123.

It should be noted that there were some early polls conducted in the United States in the late 1930s dealing with active euthanasia but they were not confined in their terms to voluntary euthanasia; for discussion, see J. Wilson, *Death by Decision* (1975) 28-36; Russell, 84-85; Humphry and Wickett, 20.

¹⁷ Gallup Poll question: 'When a person has a disease that cannot be cured, do you think that doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?'

Roper Poll question: 'When a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?'

Harris Poll question: 'Do you think that the patient who is terminally ill, with no cure in sight, ought to have the right to tell his doctor to put him out of his misery, or do you think this is wrong?'

¹⁸ Compare, for example, the results of the Gallup and Harris Polls conducted concurrently in 1973 and 1977 which indicate that respondents to the Harris Poll were significantly less supportive of the concept of active voluntary euthanasia than the respondents to the Gallup Poll.

¹⁹ Dissatisfaction has been expressed with the nature of some of these questions; see Ostheimer, 124, where he asserts that the wording used in the Gallup Poll question, particularly, the reference to ending the patient's life 'by some painless means' is ambiguous. He also suggests that the reference in the Harris Poll question, to 'put out of one's misery' is unsatisfactory because of its tendency to precondition a negative response. Other commentators agree that the Harris Poll question has a negative connotation as compared to the wording of the Gallup Poll question and that this could effect the opinions and thus account for the lower acceptance of active voluntary euthanasia in the Harris Polls; see Waller, 43-44.

| Harris Poll | | | |
|-------------|-----|---------|-----------|
| | For | Against | Undecided |
| 1973 | 37% | 53% | 10% |
| 1977 | 49% | 38% | 13% |
| 1981 | 56% | 41% | 3% |
| 1985 | 61% | 36% | 3% |

| Roper Poll | | | |
|------------|-----|---------|-----------|
| | For | Against | Undecided |
| 1986 | 62% | 27% | 10% |
| 1988 | 58% | 27% | 14% |
| 1990 | 63% | 24% | 13% |

For example, in a series of nationwide Gallup Polls in which attitudes were gauged with respect to medically administered active voluntary euthanasia,²⁰ public approval had grown from 37% in 1947 (54% disagreeing and 9% undecided) to 65% in 1990 (with 31% disagreeing and only 4% undecided). Similarly, Harris Polls, which have been conducted at regular intervals since 1973, reveal a marked increase in support for active voluntary euthanasia in the period 1973-1985 from 37% in favour in 1973 (53% against and 10% undecided) to 61% in favour in 1985 (36% against and 3% undecided).²¹ Roper Polls, which have been conducted in the United States in recent years, also indicate an overall increase in the level of public support for active voluntary euthanasia.²² In a separate survey conducted in 1985 by Associated Press-Media General, results indicated that 68% of the population believed that 'people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course' - 22% disagreeing and 10% undecided.²³

There are obviously difficulties in analysing the results of polls which have been derived from a number of separate surveys, using different survey questions. It is, nevertheless, possible to make some general observations regarding trends in survey results obtained.²⁴ According to the research by Gallup National Opinion Research Center, acceptance of active voluntary euthanasia has grown among all major population subgroups, but change has been greatest among Catholics and the younger age groups.²⁵ There appear to be no significant differences in responses based upon sex,

²⁰ See above, n. 17 for reference to the survey question.

²¹ Waller, 43-44.

²² The Hemlock Society commissioned a series of Roper Polls in 1986, 1988 and 1990. The results of these polls show an increase in levels of support for active voluntary euthanasia from 62% in 1986 to 64% in 1990. (See Table C) A Roper Poll of the West Coast was conducted in 1991 according to which 68% of respondents were in favour of active voluntary euthanasia, 23% against and 8% undecided.

²³ Associated Press-Media General, Poll No. 4. Richmond, Va.: Media General February 1985.

²⁴ For general commentary and analysis, see D. Jorgenson and R. Neubecker, 'Euthanasia: A National Survey of Attitudes Towards Voluntary Termination of Life' (1980-81) 11 *Omega* 281.

²⁵ Ostheimer, 124.

political affiliation or geographical area of the respondents.²⁶ The results of some polls indicate that age of the respondents may be a factor, with a higher approval rating amongst younger age groups.²⁷ Religious affiliation is of some significance, in that Catholics are less likely to support active voluntary euthanasia than Protestants, or non-religious persons.²⁸ Respondents with higher education, professional status and income tend to be more accepting of the concept of active voluntary euthanasia.²⁹ The race of the respondents appears to also be a relevant factor, with substantially fewer black Americans supporting active voluntary euthanasia.³⁰

Whilst there are some discrepancies in the results as between the various research organisations, possibly attributable to the different question put to respondents, overall, the polls which have been conducted in the United States over an extended period of time by a number of research organisations, reveal a steady growth in community acceptance of active voluntary euthanasia from 37% in 1947 to approximately 64% in 1990³¹ which represents a 27% increase in public acceptance of active voluntary euthanasia over a 43 year period.

Canada

Polls conducted in Canada over the past two decades also indicate a significant increase in support for active voluntary euthanasia. Since 1968, Gallup Canada have regularly conducted polls using the same poll question in which respondents were asked: 'When a person has an incurable disease that causes great suffering, do you, or do you not think that competent doctors should be allowed by law, to end the patient's life through mercy killing, if the patient has made a formal request in writing?' Although there have been some fluctuations,³² these polls of Canadian public opinion reveal growing public support for active voluntary euthanasia. (See Table D) In the most recent poll, conducted in 1991, 75% of Canadians surveyed supported the view that a doctor should be allowed by law to end the life of an incurable suffering patient at the patient's request, with only 17% opposed and 9% undecided.

Analysis of the Canadian Gallup Poll results over recent years suggests that a number of factors appear to be relevant in determining people's attitudes to active voluntary euthanasia. Age of the respondents is clearly a relevant factor, with the proportion of respondents in favour of active assistance to die being significantly lower among those over 50 years than among younger people.³³

²⁶ See, for example, the results of the 1986 Roper Poll discussed by T. Marzen, 'Euthanasia: The Handwriting on the Wall' (1988) 3 *Euthanasia Rev.* 44, 46.

²⁷ See, for example, the analysis of the Gallup Polls by Ostheimer, 124 and Waller, 45.

²⁸ See, for example, the analysis of the 1973 Gallup Poll results in Russell, 198-199; the 1986 Roper Poll discussed by Marzen, 46; and analysis of the 1990 Roper Poll results, Note, 'The 1990 Roper Poll' (1990) 39 *Hemlock Q.* 9.

²⁹ See, for example, the results of the 1986 Roper Poll, discussed by Marzen, 46.

³⁰ See, for example, the results of the 1986 Roper Poll, discussed by Marzen, 46 which indicated that only 46% of black Americans supported active voluntary euthanasia, with 39% against and 15% undecided. Note also the analysis of the Gallup Polls by Ostheimer, 124 where he states that the poll results show race to be important, but notes that racial differences on most political issues are usually dismissed as merely a function of the fact that non-whites are less educated and more fundamentalist.

³¹ This figure is based on the average for the 1990 Gallup and Roper Poll results.

³² Note, for example, the slight decline in support for active voluntary euthanasia in 1984 and 1991.

³³ See, for example, the Gallup Reports for 1989, 1990 and 1991.

Other factors which appear to be relevant include the sex of the respondents, with males marginally more in favour of allowing a doctor to end the life of a patient than are females,³⁴ as well as education and income, with the better educated and higher earning respondents more likely to be in favour of allowing a doctor to end the life of a patient at the patient's request.³⁵ There also appear to be some regional variations, with the highest proportion giving an affirmative answer in Quebec and the lowest in the prairie States.³⁶

Table D

| | For | Against | Undecided |
|------|-----|---------|-----------|
| 1968 | 45% | 43% | 12% |
| 1974 | 55% | 35% | 10% |
| 1979 | 68% | 23% | 9% |
| 1984 | 66% | 24% | 10% |
| 1989 | 77% | 17% | 6% |
| 1990 | 78% | 14% | 8% |
| 1991 | 75% | 17% | 9% |

The Gallup Polls regularly conducted in Canada since 1968, using the same survey question, represent a fairly accurate guide as to changing community attitudes in Canada to the issue of active voluntary euthanasia. These polls reveal a marked shift in public opinion since the 1968 poll, from a 45% rate of approval to 75%: this represents a 30% increase in public acceptance during the 23 year period 1968-1991.

Evaluation of Opinion Poll Results

It is evident from the foregoing review of opinion polls conducted in Australia, the United Kingdom, the United States and Canada that there has been growing public support for active voluntary euthanasia in all jurisdictions under consideration. In Australia, Gallup Polls indicate there has been a 29% increase in public support for active voluntary euthanasia since 1962, from 47% in favour in 1962 to 76% in favour in 1992. In the United Kingdom, National Opinion Polls conducted since 1976 show a steady increase in public support, with a shift from 69% in favour in 1976 to 75% in favour in 1989, a 6% increase for the 13 year period 1976-1989. In the United States reliable poll results (obtained by Gallup/N.O.R.C.) dating back to 1947 indicate a marked shift from 37% in favour in 1947 to 65% in favour in 1990; an increase of 28%.³⁷ Finally, in Canada, polls conducted by Canadian Gallup indicate a shift in public opinion since 1968 from a 45% rate of approval to 75% in favour in 1991, representing a 30% increase in public acceptance during the 23 year period 1968-1991.

³⁴ See, for example, the Gallup Reports for 1984, 1989 and 1990.

³⁵ See, for example, the Gallup Reports for 1979, 1984, 1989 and 1990.

³⁶ *Ibid.*

³⁷ Note also the 1990 Roper Poll result of 64% in favour.

Caution must be exercised in comparing poll results from different countries, where the polls have been conducted by different organisations, using different survey questions. Notwithstanding these limitations, it is possible to make some general observations, regarding trends in public opinion in all jurisdictions under consideration. There is, in fact, a remarkable degree of consistency in the public opinion results on the issue of active voluntary euthanasia obtained in Australia, the United Kingdom and Canada. According to the most recent results,³⁸ 76% in favour in Australia, 75% in favour in the United Kingdom, and 75% in favour in Canada. The level of community support appears to be somewhat less in the United States; on the basis of the most recent figures (Roper Poll 1990), 64% of those surveyed were in favour of active voluntary euthanasia. However, as in other jurisdictions, this represents an increase in the level of public support for active voluntary euthanasia. The unavoidable conclusion is that these polls reflect a growing demand for law reform to allow active voluntary euthanasia with an overwhelming majority of respondents in favour of legalisation. Indeed, to have public support in the range of 75%, as the poll results suggest, reflects quite a remarkable degree of agreement on the issue.

Apart from the overall trend towards greater acceptance of active voluntary euthanasia evident in all jurisdictions, there are a number of more specific similarities which should be noted. There is some evidence to suggest that the age of the respondent is a relevant factor in determining attitudes to active voluntary euthanasia. Younger persons are more likely to support active voluntary euthanasia, and support decreases as the age of the respondent increases.³⁹ Another factor which seems to be relevant in influencing attitudes to active voluntary euthanasia is the religious affiliation, if any, of the respondent. Whilst there has been a noticeable increase in support for active voluntary euthanasia from Catholics evidenced in the poll results,⁴⁰ there still appears to be some correlation between religious affiliation (particularly Catholic) and anti-euthanasia attitudes; generally speaking, persons who are religious are less likely to support active voluntary euthanasia than persons who are not; and more particularly, Catholics are less likely to support active voluntary euthanasia than members of other religious denominations or persons who are not religiously affiliated. The sex of the respondent is yet another factor which appears to be of some, albeit marginal, significance in influencing attitudes to active voluntary euthanasia, with males slightly more inclined than females to be in favour of allowing a doctor to assist a patient to die.

In taking an overview of all jurisdictions, it is also interesting to observe the decrease over time in the percentage of persons who were unable to answer the survey question; in Australia, it has declined since 1962 from 14% to 7% in 1991; in the United Kingdom it has declined since 1976 from 14% to 9% in 1989; in the United States the various polls also indicate an overall decline, (for example, on the basis of the Gallup Poll results there has been a decline from 9% in 1947 to 4% in 1990);⁴¹ and

³⁸ Based on figures obtained in 1991, 1989, and 1991 respectively.

³⁹ See Waller, 44-6 also for possible reasons behind these variations.

⁴⁰ See, for example, Ostheimer, 124 commenting on the results from the United States.

⁴¹ This is not supported by evidence from the Roper Polls which in fact indicate an increasing proportion of undecided respondents, but these results are not necessarily representative since they were taken over a short period (1986-1990).

in Canada it has declined since 1968 from 12% to 8% in 1990. This reduction in the number of people who are undecided on the issue of active voluntary euthanasia can probably be attributed to increased public debate on the subject over the past decade or so, with the result that more people have considered the matter and formed an opinion as to whether active voluntary euthanasia ought to be made lawful.

In sum, the clear message to law reformers is that the public is overwhelmingly in favour of active voluntary euthanasia and would support the introduction of legislation to legalise this practice in certain circumstances. As was noted in an earlier chapter, inevitably, there are those who question reliance on public opinion polls, either on the grounds that the poll questions are so vague and ambiguous that they produce unreliable results or on the ground that public opinion is an inherently unsafe and inappropriate basis for developing law and social policy.⁴²

It must be conceded that some of the survey questions used could have been more clearly and appropriately expressed⁴³ and that this in turn may have some bearing on the responses that those questions would elicit. In part, the problem stems from the need for consistency in the survey question if one is attempting to follow trends in public opinion over an extended period of time. Thus, once a survey question has been in use for a time, it gains a certain currency, and is unlikely to be changed, even though a contemporary compilation of the issues would perhaps be differently expressed. However, having conceded some difficulties with some of the survey questions currently in use, these difficulties must not be overstated, and certainly cannot be legitimately invoked to undermine or discredit the overall impact of the opinion polls which provide overwhelming evidence of growing public support for active voluntary euthanasia.

More fundamental is the objection that notwithstanding widespread public support for active voluntary euthanasia, it is, in any event, not appropriate to base the law on the opinion of the majority.⁴⁴ In response it can be argued that although in general, strength of numbers for a particular reform is clearly not, of itself, a valid basis for a change in the law, where, as is the case with regard to active voluntary euthanasia, there are weighty substantive arguments in favour of reform, evidence of public demand for such change can only operate to strengthen the case for reform.

The literature is sparse on reasons behind this shift in public opinion. Whilst any explanation as to the basis for growing public support for active voluntary euthanasia can at best be speculative, a number of inferences can be drawn. In recent decades, the issue of active voluntary euthanasia has been

⁴² B. Pollard, *Euthanasia* (1989) 59-62; G. Grisez and J.M. Boyle, *Life and Death with Liberty and Justice* (1979) 14; British Medical Association (B.M.A.) Working Party Report, *Euthanasia* (1988) 42. For further discussion, see chapter V, 195.

⁴³ Some commentators, for example Pollard, 59-62, have been critical of references in some of the poll questions to patients being 'helped' or 'assisted' to die since this could be taken to cover either active voluntary euthanasia or palliative care or both. Indeed, some opponents of euthanasia who challenge the validity of polls results have suggested that in many instances the survey question is deliberately framed to conceal the real issues and obtain a favourable response; see Grisez and Boyle, 13-14.

⁴⁴ Pollard, 62; B.M.A. Working Party Report, *Euthanasia*, 42. See chapter V, 195.

increasingly brought to the attention of the public. The media has played a significant role in promoting the debate about active voluntary euthanasia as have the voluntary euthanasia societies which have been established in all jurisdictions. As a result of growing community debate on the subject, the public is better informed about the issue and has increasingly swung its support behind the legalisation of active voluntary euthanasia. Other factors contributing to the increasing preparedness of the public to sanction active voluntary euthanasia are the changing attitudes to death and the diminishing effectiveness of religious and cultural strictures against the taking of life. Accompanying this changed outlook to death and dying, there has been increased attention to patients' rights and the principles of patient autonomy and self-determination. There is evidence of growing concern amongst members of the public that they may fall victim to developments in medical technology. This has resulted in a desire for individuals to re-establish control over the manner of their dying. The public is also likely to be sensitive to changing attitudes within the medical profession on the subject of active voluntary euthanasia, with media reports of doctors indicating their support for the practice and on occasion being involved in its administration.

It must be emphasised that these changes in community attitudes have come about over a number of decades,⁴⁵ so the process of change has been gradual. On the basis of poll results, there is some evidence to suggest that the pace of change has accelerated in the past decade,⁴⁶ reflecting the increased level of public interest in the subject of active voluntary euthanasia and the growing momentum of the voluntary euthanasia movement during this period.

PART II

The Voluntary Euthanasia Movement

The upsurge in public support for active voluntary euthanasia has also been manifest in growing community action. Voluntary euthanasia societies have been established in Australia and overseas for the purpose of working towards the legalisation of active voluntary euthanasia, and they have greatly contributed to the growing momentum of the voluntary euthanasia movement. In response to these developments, there has also been organised opposition to the legalisation of active voluntary euthanasia from various right to life groups as well as other anti-euthanasia organisations specifically established to counter the growing campaign for legalisation.

⁴⁵ For example, the Morgan Gallup Poll results gauging the attitudes of Australians to active voluntary euthanasia have been conducted since 1962.

⁴⁶ See, for example, the Morgan Gallup Poll results for Australia in the period 1986-1990 during which there was a 10% increase in public support. Note also a similar development in Canada for the period 1984-1990 during which there was a 12% increase.

Voluntary Euthanasia Societies

Australia and New Zealand

Since the mid 1970s, a number of voluntary euthanasia societies have been established in Australia and New Zealand. With the exception of the Northern Territory, voluntary euthanasia societies now exist in all Australian States and Territories, and societies have been established in a number of cities in New Zealand. The first Australian societies to be established were the Australian Voluntary Euthanasia Society, based in New South Wales, (later renamed the Voluntary Euthanasia Society of New South Wales) and the Voluntary Euthanasia Society of Victoria, both of which were established in February 1974.⁴⁷ Similar developments occurred in New Zealand with the establishment in 1978 of voluntary euthanasia societies in Auckland and Wellington. In the 1980s, a number of further societies were formed in Australia; the West Australian Voluntary Euthanasia Society (W.A.V.E.S.) established in March 1980, the South Australian Voluntary Euthanasia Society (S.A.V.E.S.) established in 1983, the Voluntary Euthanasia Society of Queensland established in 1987 and the Voluntary Euthanasia Society of Tasmania established in 1992. Branches of the Voluntary Euthanasia Society of New South Wales have been formed in Canberra in 1986 and in Newcastle in 1988. Most of the voluntary euthanasia societies are incorporated.

The justification for the creation of separate societies in Australia is primarily because of this country's federal structure and of the fact that the reforms being sought are in the criminal law field and are therefore a matter within the responsibility of the State and Territory legislatures. As a result, the campaign for reform has been focussed at the State and Territory level.⁴⁸ However, with the rapid expansion of the voluntary euthanasia movement in the 1980s, there was growing recognition of the need for closer co-operation between the State organisations, and in 1987 the Australian societies joined in a Federation of Australian Voluntary Euthanasia Societies (F.A.V.E.S.) in an attempt to co-ordinate their activities.⁴⁹ In 1988 V.E.S. (Auckland) was admitted to F.A.V.E.S., which then became the Federation of Australasian Voluntary Euthanasia Societies. However, this organisation did not operate as effectively as was hoped, and has since been disbanded.

Thus, although all of the Australian and New Zealand societies pursue similar objectives and policies, each is a separate and independent body and they have generally pursued their activities independently. Most of the societies are, however, affiliated with the World Federation of Right to Die Societies, formed in 1980.⁵⁰ The main objective of all the Australian and New Zealand societies is, essentially, to promote public understanding and acceptance of active voluntary euthanasia and to secure reform of

⁴⁷ Voluntary Euthanasia Society (V.E.S.) Vic. *Voluntary Euthanasia* (Revised ed., 1982) 5.

⁴⁸ V.E.S. Vic. *Voluntary Euthanasia*, 5.

⁴⁹ The terms of reference for F.A.V.E.S. were as follows; To present the views of member societies at a national level, to co-ordinate and facilitate the activities of voluntary euthanasia societies throughout Australia, to promote and assist the formation of further voluntary euthanasia societies, to arrange national and regional conferences, to publish a national newsletter and other literature relevant to voluntary euthanasia and to represent the Australian voluntary euthanasia movement internationally.

⁵⁰ V.E.S. Vic. *Voluntary Euthanasia*, 5.

the law so that active voluntary euthanasia should become lawful.⁵¹ The statement of aims contained in the literature for the Victorian, New South Wales and Queensland societies is fairly representative:

The aim of the Society is to promote legislation giving effect to the widely held public opinion that any person suffering, through illness or disability severe pain or distress for which no remedy is available, should be entitled by law to a painless and dignified death in accordance with that person's expressed direction.⁵²

However, the executive bodies of most of the societies have recognised that the legalisation of active voluntary euthanasia is realistically a long-term goal, and they have consequently set themselves more readily achievable objectives for the more immediate future. These objectives include encouraging people to make a 'living will' or advance directive, increasing patients' awareness of their rights, ensuring that pain control education is an integral part of medical training, and lobbying governments to set up more hospices.⁵³ In some States, the voluntary euthanasia societies have played an active role with regard to the passage of legislation dealing with the refusal of treatment and passive euthanasia.⁵⁴

In more recent years, the societies have been very active in their attempts to secure reform with regard to active voluntary euthanasia, engaging in a wide range of activities. To a large extent, their activities are directed at increasing public awareness and acceptance of active voluntary euthanasia. In pursuit of these aims, the societies issue regular newsletters,⁵⁵ handle many telephone calls and inquiries⁵⁶ and generally seek to disseminate information to the community about active voluntary euthanasia.⁵⁷ All of the societies have published educational material outlining their aims and the relevant issues in the debate regarding legalisation of active voluntary euthanasia.⁵⁸ Many of the societies have secured notable patrons to assist in promoting their societies objectives.⁵⁹ Representatives of the societies frequently present lectures at the request of various groups and

⁵¹ See, for example, the S.A.V.E.S. Constitution.

⁵² See, for example, the newsletters of the V.E.S. of Vic., V.E.S. of Qld. and the V.E.S. N.S.W. and their memorandum and articles of association.

⁵³ This is, for example, the position adopted by the V.E.S. of N.S.W. Executive; see the Editorial (1989) 50 *V.E.S. of N.S.W. Newsletter* 2.

⁵⁴ This was the case particularly in Victoria with regard to the major inquiry by the Parliament of Victoria Social Development Committee into Options for Dying with Dignity and the resulting Medical Treatment legislation. W.A.V.E.S. has also played a role in the Law Reform Commission of Western Australian reference on Medical Treatment for the Dying. For further discussion of these developments, see chapter VII, 301-313.

⁵⁵ The newsletters for the Australian societies are as follows; *V.E.S.V. Report*; *S.A.V.E.S. Bull.*; *V.E.S. of N.S.W. Newsletter*; *V.E.S.Q. Newsletter*; *V.E.S. Tas. Newsletter*; *W.A.V.E.S. News*.

⁵⁶ This information was obtained as a result of interviews with representatives from all of the Australian voluntary euthanasia societies conducted in 1989-1992.

⁵⁷ Indeed, difficulties often arise when an individual phones the society, seeking specific information on how to commit suicide. Society representatives are very much aware of potential criminal liability for assisting suicide if they divulge such information. In the literature of some of the societies it is made clear that in view of the present law regarding assisted suicide, the society can under no circumstances help anyone to commit suicide; e.g. Note, 'Sorry - Can't Help' (1989) Vol. 9 No. 3 *W.A.V.E.S. News* 1.

⁵⁸ For example, booklets such as the V.E.S. Vic., *Voluntary Euthanasia* V.E.S. of N.S.W., *Voluntary Euthanasia* (1991) as well as brochures and information sheets.

⁵⁹ Professor Peter Baume A.O. is the patron for V.E.S. of N.S.W.; the Honourable R.A. Mackenzie M.L.C. is the patron for V.E.S. Vic.; Sir Mark Oliphant is the patron for S.A.V.E.S.; and Janet Holmes a Court is the patron for W.A.V.E.S.

organisations, appear on television and give radio interviews. Public meetings are regularly arranged by the societies, often with well-known guest speakers, as well as seminars, workshops and educative displays.⁶⁰ In furtherance of this ongoing educative program, all societies endeavour to send representatives to the regular international voluntary euthanasia conferences.⁶¹ The societies are also involved in more direct attempts at securing reform for active voluntary euthanasia, including political campaigning⁶² and the preparation of submissions to governmental and law reform commission inquiries.⁶³ In recent years, a number of the societies have undertaken specific steps towards the introduction of legislation for the legalisation of active voluntary euthanasia.⁶⁴ Efforts have also been made by some societies to promote dialogue within the medical profession on the subject of active voluntary euthanasia and to encourage the interchange of views with society representatives. Invitations have been extended to the medical profession to the societies' public meetings and seminars, and the societies have also been responsible for the publication and distribution of material directed at the medical profession, such as the booklet *Voluntary Euthanasia and the Medical Profession: An Invitation to Dialogue* produced by the S.A.V.E.S.⁶⁵ A number of the societies have now set up groups of doctors and nurses to work on health care aspects of voluntary euthanasia.⁶⁶

Membership to these societies is open to all adults who are in agreement with the societies' aims. Over the years, the societies have attracted members from a wide range of social, economic, political, philosophical and religious backgrounds.⁶⁷ Membership has increased substantially since the societies

⁶⁰ For example, the Speakers' Corner Display arranged by the S.A.V.E.S. in the Old Parliament House Building, April 1988.

⁶¹ The World Federation of the Right to Die Societies established in 1980, holds an International Conference every two years.

⁶² A popular method has been to write to politicians to inform them of the aims of the voluntary euthanasia societies, to seek their views on the subject and generally to encourage support for the legalisation of active voluntary euthanasia. Some societies have also been involved in the collection of signatures for a parliamentary petition; see Note, 'The Parliamentary Petition' (1989) Vol. 9 No. 4 *W.A.V.E.S. News* 2.

⁶³ For example in Victoria, the submission by the V.E.S. Vic. in 1986 to the Parliament of Victoria Social Development Committee in connection with the Inquiry into Options for Dying with Dignity; the submission by W.A.V.E.S. to the West Australian Law Reform Commission in connection with its reference on Medical Treatment for the Dying in 1988; and the submission by S.A.V.E.S. to the South Australian Parliamentary Select Committee on the Law and Practice Relation to Death and Dying in 1991. For further discussion of these inquiries see chapter VII, 297-313.

⁶⁴ For example, S.A.V.E.S. established a Task Force in 1988 to examine and report on the possibilities for legislative reform and to formulate plans for introducing active voluntary euthanasia legislation in South Australia; see Note, 'Proposals for Legislative Change: S.A.V.E.S. Task Force Report' (1989) Vol. 6 No. 2 *S.A.V.E.S. Bull.* 5-7. The Task Force has drafted a paper entitled, a 'Discussion Paper on Decriminalising Voluntary Euthanasia in South Australia' (1989); see discussed in Note, 'Task Force Progress Report' (1990) Vol. 7 No. 2 *S.A.V.E.S. Bull.* 6. A number of the societies, including V.E.S. of N.S.W. and V.E.S. of Vic. have been working on proposals for the legalisation of doctor-assisted suicide as an intermediate goal.

⁶⁵ (1990).

⁶⁶ In South Australia, a group of doctors has been established called the Association of Medical Practitioners Concerned with Assisted Dying. At the time of writing, moves were underway to set up of a group of doctors and a group of nurses in Victoria; Note, 'Voluntary Euthanasia Groups of Doctors and of Nurses Proposed' (1992) 76 *V.E.S.V. Report* 5. According to recent figures, membership numbers for the various Australian voluntary euthanasia societies are as follows; S.A.V.E.S. 780; V.E.S. N.S.W. 2,250; V.E.S. Qld. 526; V.E.S. Vic. 1,500; and W.A.V.E.S. 1303. At the time of writing, the newly established V.E.S.Tas. already had approximately 50 members.

⁶⁷ V.E.S. Vic. *Voluntary Euthanasia*, 5; S.A.V.E.S. *The Right to Choose* (2nd ed. 1990) 36.

were first established, with particular growth having been experienced since the 1980s coinciding with increased media exposure and public debate on the subject.⁶⁸

United Kingdom

There are two voluntary euthanasia societies in the United Kingdom; the Voluntary Euthanasia Society (Britain) based in London, and the Voluntary Euthanasia Society of Scotland based in Edinburgh.⁶⁹ The history of the voluntary euthanasia societies in the United Kingdom, particularly the British Voluntary Euthanasia Society, is of special interest because of the early origins of the society and its active involvement since the mid 1930s in efforts to secure legislative reform. Also of interest is the controversy surrounding the society in the early 1980s in connection with the publication of a suicide manual and the imprisonment of some members of the society for having assisted the suicide of a number of persons.

British Voluntary Euthanasia Society

The origins of the British Voluntary Euthanasia Society established in 1935 and the early attempts at legislative reform in 1936 are well documented.⁷⁰ Most commentators agree that the contemporary movement for active voluntary euthanasia in the United Kingdom began with a Presidential address by Dr C. Millard in 1931 to the Society of Medical Officers of Health, entitled 'A Plea for the Legalisation of Voluntary Euthanasia'.⁷¹ Millard's address was subsequently published,⁷² together with a proposed draft Bill for the legalisation of active voluntary euthanasia⁷³ and it received widespread publicity. In the years which followed, Millard communicated with members of the medical and other professions who were interested in his proposal and in 1935, the Voluntary Euthanasia Legalisation Society (Britain) was officially formed under the Presidency of Lord Moynihan, with the specific purpose of promoting the draft Bill which Millard had proposed.⁷⁴ Under the guidance of Millard, in his capacity as Honorary Secretary, and Lord Moynihan as President - both well respected doctors - the society enjoyed the support of many of Britain's most distinguished doctors, public figures and clergymen.⁷⁵ Although the *Voluntary Euthanasia (Legalisation) Bill* introduced by Lord Ponsonby in the House of Lords in November 1936 was ultimately unsuccessful,

⁶⁸ In fact, the societies have, on occasion, reported significant increases in membership following some well publicised case or incident which raises the public awareness with respect to active voluntary euthanasia. See, for example, the *Bulletin* 19 April 1988, 43 referring to a report of the V.E.S. of N.S.W. to the effect that 200 people joined the society as a result of the debate on 'death with dignity' which followed the double suicide of Sir John and Lady Phillips.

⁶⁹ For a number of years there was a third organisation in the United Kingdom, called New Exit. It was established in 1983 as a splinter group of the Voluntary Euthanasia Society (Britain) but ceased to exist in 1988.

⁷⁰ For literature tracing the history of the society, see, for example, I. van der Sluis, 'The Movement for Euthanasia' (1979) 66 *Janus* 131, 148-154; H. Trowell, *The Unfinished Debate on Euthanasia* (1973) 14-15; G. Williams, *The Sanctity of Life and the Criminal Law* (1956) 293-302.

⁷¹ For example, Williams, 294; van der Sluis, 148; J. Gould and Lord Craigmyle, (eds.) *Your Death Warrant?* (1971) 24.

⁷² Millard's address was published in *Public Health* Nov. (1931) and was released as a pamphlet shortly afterwards.

⁷³ *The Voluntary Euthanasia (Legalisation) Bill*. For discussion of this Bill see chapter VII, 318-319.

⁷⁴ The stated aim of the society was 'to create a public opinion favourable to the view that an adult person suffering from a fatal illness, for which no cure is known, should be entitled by law to the mercy of a painless death if and when that is his expressed wish: and to promote this legislation'; see Trowell, 15.

⁷⁵ Williams, 295; Russell, 67.

it stimulated considerable public interest and discussion of the issue, and brought many new members and supporters to the society.⁷⁶ In the ensuing years, the society, with Millard as its chief spokesman, continued to campaign for legalisation of active voluntary euthanasia, though it was in fact some decades before voluntary legislation was again introduced into parliament.⁷⁷

With the outbreak of World War II and the negative connotations given to the word 'euthanasia' as a result of the Nazi atrocities, there was a definite reduction in action and publication pertaining to euthanasia in the early 1940s and a perceived shift in public sentiment away from active voluntary euthanasia.⁷⁸ The Voluntary Euthanasia Society nevertheless remained active during this time continuing in its efforts to secure reform.⁷⁹ The society, which had begun as the Voluntary Euthanasia Legalisation Society, had at one time discarded the words 'Voluntary' and 'Legalisation' from its name but in 1969 reinstated the word 'Voluntary', so that it became The Voluntary Euthanasia Society.⁸⁰

In 1979, following its annual meeting, the society changed its name to 'Exit,' for the sake of modernity.⁸¹ One commentator⁸² has suggested that the change of name was more a product of the society's growing disillusionment with its failure to secure reform and signalled the adoption of more direct tactics in pursuing the society's objectives. In the same year, a proposal had been mooted for the publication by the society of a practical guide to rational suicide - a do-it-yourself manual as a stopgap expedient pending the legalisation of active voluntary euthanasia.⁸³ Although the majority of members supported this proposal, the executive of the newly named Exit society was divided over the matter.⁸⁴ After the election of a new executive and appropriate amendments to the society's constitution so as to bring such a publication within its purview,⁸⁵ the society eventually proceeded with the publication of a booklet in 1981 on methods of suicide entitled *A Guide to Self-Deliverance*. Sales of the booklet were restricted to members of three months standing who were over 25 years of age and each copy was numbered so that its purchaser could be traced if necessary.⁸⁶ However, the legality of the publication and distribution of this booklet was subsequently challenged by the Director of Public Prosecutions. Initially, criminal prosecution was threatened on the grounds of contravention of s. 2 of the *Suicide Act 1961* (Eng.). The proceedings which did in fact result took the

⁷⁶ A. Downing and B. Smoker, (eds.) *Voluntary Euthanasia* (1986) 256.

⁷⁷ In 1950, the activities of the society had resulted in a debate in the House of Lords on a motion in favour of the principle underlying voluntary euthanasia, however, the motion was withdrawn without a vote due to strong opposition. It was not until 1962 that a new Bill was drafted and publicly proposed, and this Bill was not introduced into Parliament and voted on until 1969 (*Voluntary Euthanasia Bill 1969*); see Russell, 111.

⁷⁸ Russell, 87.

⁷⁹ *Id.* 110-111.

⁸⁰ Downing and Smoker, 256.

⁸¹ *Ibid.* See also Note, 'The Voluntary Euthanasia Society: A Historical Note' (1985) 24 *V.E.S. Newsletter* 4-5.

⁸² S. Potts, 'Looking for the Exit Door: Killing and Caring in Modern Medicine' (1988) 25 *Hous.L.Rev.* 493, 494.

⁸³ Downing and Smoker, 256.

⁸⁴ *Id.* 256-257.

⁸⁵ *Id.* 257.

⁸⁶ Humphry and Wickett, 220.

form of an application brought by the Attorney-General to the High Court for a declaration of illegality under s. 2 of the *Suicide Act* 1961 (Eng.). In a hearing which came before the court in April 1983, Justice Woolf refused to grant the Attorney-General's application holding that the publication of such material was not of itself unlawful.⁸⁷ However, he held that whether or not the distribution of these booklets was legal would depend on whether there was, at the time, an intent to assist those who are contemplating suicide and further, that the person contemplating suicide was in fact assisted or encouraged, by reading the booklet, to attempt to take his or her own life.⁸⁸ Justice Woolf was of the view, that the legality of publication and distribution could not be determined in advance based on hypothetical circumstances - in each case the jury would have to decide whether the necessary facts were proved.⁸⁹ In the light of this decision, the society decided against further publication and distribution of the booklet.⁹⁰ However, the publicity surrounding the publication of the booklet, even prior to its actual release, and then in connection with the resulting litigation, proved to be a boon to the society, resulting in a substantial increase in the society's membership.⁹¹

At about the same time, the society attracted adverse publicity, when the then Secretary of the society, Nicholas Reed, and a long-time volunteer worker for the society, Mark Lyons, were tried for their involvement in assisting suicide and conspiracy to assist suicide.⁹² Reed was found guilty on four counts and was sentenced to two and a half years imprisonment. On appeal, this was later reduced to eighteen months. Lyons was also found guilty on a number of counts, but since he had been in custody awaiting trial for nearly a year, he was released on a two year suspended sentence.⁹³ Although the society was quick to dissociate itself from the Reed-Lyons affair, affirming its intention to operate within the limits of the law, its public image was seriously damaged as a result of this case. The society's objectives had never endorsed the concept of active euthanasia or assisted suicide for depressed or disturbed people, so it was particularly damaging when evidence at the trial revealed that some of the individuals who had been helped or offered help to commit suicide were mentally ill, depressive or alcoholics.⁹⁴ Indeed, according to the former chairman of the executive committee, the society subsequently found it an uphill struggle to regain its reputation as a respectable pressure group rather than as a 'suicide club' as *The Times* newspaper had dubbed it.⁹⁵

In 1981, the society dropped the name 'Exit' and reverted back to its former name (The Voluntary Euthanasia Society) primarily in an attempt to distance itself from the adverse publicity that the

⁸⁷ *Attorney-General v Able* [1983] 3 W.L.R. 845. For more detailed analysis of this case, see chapter III, 85-87.

⁸⁸ *Id.* 858.

⁸⁹ *Id.* 858-859.

⁹⁰ Downing and Smoker, 257-258.

⁹¹ The pre-publication publicity brought a sudden surge of membership from about 2,000 to 11,000; see Downing and Smoker, 257.

⁹² Humphry and Wickett, 215-220; Downing and Smoker, 256.

⁹³ Humphry and Wickett, 218.

⁹⁴ *Id.* 219.

⁹⁵ *The Times*, 31 Oct. 1981.

society had sustained as a result of the Reed-Lyons case. In fact it is only in more recent years that the society has recovered from the negative public image that it acquired as a result of that case.⁹⁶

The principal object of the Voluntary Euthanasia Society is to promote legislation which would allow an adult person, suffering from a severe illness to which no relief is known, to receive an immediate painless death, if that is the patient's expressed wish.⁹⁷ Over the years, the society has been very active in its efforts to secure reform of the law in this area, having been responsible for commissioning opinion polls, lobbying politicians, campaigning for reform,⁹⁸ and preparing draft legislation for the legalisation of active voluntary euthanasia.⁹⁹ The society publishes a quarterly newsletter and accepts frequent invitations to speak to various groups and conduct media interviews to discuss the society's aims and activities.¹⁰⁰ The society is also active in the promotion and distribution of 'advance directives'¹⁰¹ and has prepared draft legislation for the statutory recognition of such directives.¹⁰²

Membership of the society is steadily increasing and is open to all who sympathise with the society's objects. In the wake of the activities of the British Medical Association Working Party on Euthanasia, the society established a medical group made up of doctor members of the society.¹⁰³ This group has extended its membership to include nurses, and other health care workers.¹⁰⁴

Voluntary Euthanasia Society of Scotland

The Voluntary Euthanasia Society of Scotland (originally named Scottish EXIT), was established in 1980 as a breakaway organisation from EXIT (England) as it was then known. Prior to that time, a Scottish regional branch of EXIT (England) had been operating in Scotland - 'Scottish Region EXIT'. However, disagreement had arisen between the executive of EXIT (England) and the Scottish branch over plans by the Scottish branch to publish a booklet on self-deliverance. When the Acting Chairman of EXIT (England) forbade publication of the proposed booklet, the Scottish members decided to declare independence from EXIT (England) and to continue as a separate entity. Thus, the newly created Scottish EXIT, taking advantage of more lenient conditions that prevail under Scottish law, became the first organisation to publish a booklet on self-deliverance.¹⁰⁵ The publication

⁹⁶ Note, 'The Tide Begins to Turn' (1988) 33 *V.E.S. Newsletter* 1.

⁹⁷ Booklet published by the Voluntary Euthanasia Society, *The Last Right* (1988) 1.

⁹⁸ For example, the society has conducted questionnaires of M.P.s and active members of the House of Lords for their views on active voluntary euthanasia and through its newsletters, has encouraged members to write to their M.P.s to urge them to support steps for reform in this area; e.g. Note, 'Your Help Needed' (1990) 38 *V.E.S. Newsletter* 1.

⁹⁹ See chapter VII, 318-320.

¹⁰⁰ Information from interview with society representatives. The activities of the society are well documented in its newsletters.

¹⁰¹ See, for example, the Voluntary Euthanasia Society booklet, *The Last Right*, 7 and other literature distributed by the society.

¹⁰² *Medical Treatment (Advance Directives) Bill*. See also J. Davies, 'The Advance Directive' (1991) 4 *J. Med. Defence Union* 92.

¹⁰³ Minutes of the Annual General Meeting 1988 (1988) 35 *V.E.S. Newsletter* 2.

¹⁰⁴ Note, 'To All Nurses' (1989) 36 *V.E.S. Newsletter* 6.

¹⁰⁵ Downing and Smoker, 257. For further consideration of the legal position in Scotland, see chapter III, n. 11.

entitled *How to Die with Dignity*¹⁰⁶ was first released in September 1980, and since then has been available for strictly private distribution amongst members of the society.¹⁰⁷ In 1983, the society changed its name from Scottish Exit to its present name, the Voluntary Euthanasia Society of Scotland. The aims are much the same as for other voluntary euthanasia societies, namely to ultimately secure reform of the law so as to permit active voluntary euthanasia.¹⁰⁸ The society is involved in a wide range of activities, including public meetings, media interviews, press publicity and lobbying of politicians.¹⁰⁹

United States

In the wake of developments in the United Kingdom, the Euthanasia Society of America was founded in 1938. The founder and first President of the society was the Reverend Charles Francis Potter, a humanist and prolific writer of books on religion. As had been the case in the United Kingdom, the Euthanasia Society of America was involved in early, but unsuccessful attempts to introduce legislation to legalise active euthanasia. A euthanasia Bill was prepared by the society formulated broadly along the same lines as the 1936 English Bill and was submitted, with some differences in content,¹¹⁰ to the New York State and Nebraska assemblies in the late 1930s.¹¹¹ However, neither Bill was enacted. Initially, the aims of the Euthanasia Society of America had extended to the legalisation of non-voluntary euthanasia in certain circumstances.¹¹² In the light of the results of a survey of doctors conducted by the society in 1941, which indicated substantial approval for voluntary as distinct from non-voluntary euthanasia,¹¹³ it was decided to confine the activities of the society to strictly voluntary euthanasia, notwithstanding that some polls of public opinion had shown support for euthanasia of grossly defective infants.¹¹⁴

During the 1940s and early 1950s, concerted efforts were made by the society to introduce legislation in New York to permit active voluntary euthanasia but these efforts were repeatedly thwarted for lack of a sponsor for the legislation.¹¹⁵ Parallel attempts in other American States also proved fruitless.¹¹⁶ In view of the previous failed attempts at legislative reform, the society decided that further attempts to introduce legislation would be futile until a more favourable climate of opinion

¹⁰⁶ G. Mair, (1980).

¹⁰⁷ See *How to Die with Dignity*, 5 for the conditions of circulation and use of the booklet.

¹⁰⁸ See booklet produced by the V.E.S.S. *Voluntary Euthanasia* (1990).

¹⁰⁹ Information obtained through correspondence with society representatives, 1990-1992.

¹¹⁰ The Nebraska Bill differed from both the New York Bill and the legislation which had been proposed in the United Kingdom on the grounds that it authorised a limited form of non-voluntary euthanasia of minors and incompetent adults. It was also broader in scope in that it provided that active euthanasia could be performed even where the illness was not terminal. See R. Kaplan, 'Euthanasia Legislation: A Survey and a Model Act' (1976) 2 *Am.J.L. & Med.* 41, 53.

¹¹¹ Williams, 296.

¹¹² Gould and Craigmyle, 26 referring to the proposal to advocate compulsory euthanasia of 'monstrosities and imbeciles'; Humphry and Wickett, 16; Russell, 72-74 referring to individuals connected with the society (including its founder and President, Rev. Charles Potter) who had supported the concept of non-voluntary euthanasia in some circumstances.

¹¹³ Humphry and Wickett, 36; Russell, 89-90.

¹¹⁴ Humphry and Wickett, 36; Russell, 90.

¹¹⁵ For fuller consideration of the various early attempts at legislative reform in the United States see chapter VII, 324-326.

¹¹⁶ Russell, 133-135 referring to developments in the 1950s in New Jersey and Connecticut.

had been created.¹¹⁷ However, the society's efforts at legislative reform had at least succeeded in drawing attention to the society and its objectives and attracting some prominent supporters for its cause, including many doctors and clergy.¹¹⁸

During the 1960s, under the new Presidency of Donald McKinney, a Unitarian minister, there was some reassessment of the organisation's goals with increasing emphasis on the right of the individual to consent to and refuse treatment.¹¹⁹ Although there were some who still believed in pressing for legislation for the legalisation of active voluntary euthanasia, the majority of the then board of directors saw education of the public and the health care professions as the primary need and the activities of the society were directed towards education rather than legislation.¹²⁰ Pursuant to this shift in focus, the society established the Euthanasia Educational Fund in 1967, (subsequently named the Euthanasia Educational Council in 1972), a tax-exempt branch of the society, the function of which was to disseminate information and promote discussion on the issues involved in death and dying.¹²¹ In the mid 1970s, when the prospects of introducing legislation had improved, the politically active counterpart of the council, the Euthanasia Society of America, was reactivated as the Society for the Right to Die to promote State 'right to die' legislation. In 1978, the Euthanasia Educational Council changed its name to Concern for Dying. For some years, the Society for the Right to Die and Concern for Dying were affiliated, operating as separate arms of the American right to die movement and sharing the same office premises.¹²² Because of the Euthanasia Educational Council's tax exempt non-profit status, euthanasia supporters were encouraged to send donations which were in turn partly used to finance the activities of the Society for the Right to Die.¹²³ However, the tensions underlying the differing orientations of the two groups eventually led to a complete split in 1979.¹²⁴

Concern for Dying, with its essentially educational outlook, continued with its program of public and professional education and dissemination of its living will.¹²⁵ In addition to the publication of a quarterly newsletter which commenced in 1975, and reports on legal, medical and ethical developments in the care of the dying, Concern for Dying produced a significant amount of literature on the subject of death and dying¹²⁶ as well as a number of educational films and videotapes.¹²⁷ A major program activity of Concern for Dying was the Interdisciplinary Collaboration on Death and Dying. First established in 1978, the Interdisciplinary Collaboration on Death and Dying (known as the

¹¹⁷ *Id.* 132-133, 180.

¹¹⁸ Wilson, 37; Humphry and Wickett, 37; J. Sullivan, *The Morality of Mercy Killings* (1950) 18-21.

¹¹⁹ Concern for Dying, *A Twenty - Year History* 1967-1987.

¹²⁰ *Ibid.* See also Russell, 180.

¹²¹ Humphry and Wickett, 95; Russell 180; Wilson, 41.

¹²² Society for the Right to Die, *The First Fifty Years* 1938-1988, 3; Humphry and Wickett, 119.

¹²³ Humphry and Wickett, 119.

¹²⁴ For more detailed coverage of the breakdown in the organisations' working relationship and the litigation which ensued, see Humphry and Wickett, 119-120.

¹²⁵ See Concern for Dying, *A Twenty - Year History* 1967-1987.

¹²⁶ See, for example, the *Legal Guide to the Living Will* (1978) and *The Living Will and Other Advance Directives* (1986).

¹²⁷ See pamphlet, Concern for Dying, Films and Videotapes.

Collaboration) is a professional educational program on terminal care decision-making for students and practitioners in law, medicine, nursing, social work, theology, health care administration and related professions with the aim of improving participants' understanding and skill in dealing with the needs of the terminally ill and their families.¹²⁸ Another initiative introduced by Concern for Dying was the establishment of a living will registry in 1983, whereby individuals can, for a small fee, have a copy of their living will kept on a computerised file in a central location.¹²⁹ During the 1980s, Concern for Dying began to diversify its activities into the judicial and legislative areas. A legal advisory service was established to handle the numerous inquiries from attorneys for information about the legal status of non-statutory advance directives and other legal questions pertaining to the terminally ill. Concern's staff attorney and committee members have been involved in a number of court cases, giving legal advice as well as filing *amicus* briefs in a number of landmark cases.¹³⁰ The organisation has also been involved in drafting model 'right to refuse treatment' legislation.

Following its official separation from Concern for Dying in 1979, the more politically active group, the Society for the Right to Die, continued with its campaign for right to die legislation and has been instrumental in securing reform in this area.¹³¹ However, the split between the two organisations resulted in an expansion of the society's program into educational and judicial arenas, while continuing with its legislative activities.¹³² In addition to the publication and distribution of its newsletters, the society produced numerous publications dealing with living wills and relevant legislation and generally on the subject of 'death with dignity'.¹³³ In 1984, a legal department was established and the society has been involved in many 'right to die' court cases, with staff attorneys acting as advocates or more usually, submitting *amicus* briefs in support of the patient's right to refuse life-sustaining treatment.¹³⁴ The society has also been active in the medical field. In 1985, the society established a medical relations department, with the aim of promoting closer contact between the society and health care facilities.¹³⁵ The society has also regularly sponsored conferences for doctors to foster the exchange of views on right to die issues among medical practitioners. In 1982 the society convened a conference of ten of the nation's most prominent doctors with the aim of establishing comprehensive guidelines on the doctors' responsibility towards hopelessly ill patients and their families. This initiative led to the publication of an authoritative article in the *New England Journal of Medicine*¹³⁶ which was subsequently also incorporated in the society's own publication,

¹²⁸ See Concern for Dying, *A Twenty - Year History 1967-1987*.

¹²⁹ *Ibid.*

¹³⁰ Concern for Dying, *The Living Will and Other Advance Directives* (1986) 4.

¹³¹ In 1978 the society was involved in drafting model living will legislation in conjunction with the Yale Legislative Services at the Yale Law School. The draft legislation has subsequently been used as a legislative model in a number of jurisdictions; Society for the Right to Die, *The First Fifty Years 1938-1988*, 4-5.

¹³² Society for the Right to Die, *The First Fifty Years 1938-1988*, 5.

¹³³ The society's publications include *Death with Dignity: Legislative Manual* (1975); *Handbook of Living Will Laws 1981-1984*; *The Handbook of 1985 Living Will Laws* (1985); *Handbook of Living Will Laws* (1987 edition); and *The Physician and the Hopelessly Ill Patient* (1985).

¹³⁴ Society for the Right to Die, *The First Fifty Years 1938-1988*, 9.

¹³⁵ *Id.* 7.

¹³⁶ S. Wanzer *et al.*, 'The Physician's Responsibility to the Hopelessly Ill Patient' (1984) 310 *New Eng.J.Med.* 955.

*The Physician and the Hopelessly Ill Patient: Legal, Medical and Ethical Guidelines*¹³⁷ and has been widely distributed amongst the health care community. Encouraged by the success of the 1982 conference, the doctors were convened by the society for a second time in 1987 in order to continue their analysis of the doctors' appropriate role with dying patients. Nine of the original ten participants were present (one of the doctors had since died) and there were three additions. This second conference resulted in a follow up publication in the *New England Journal of Medicine*,¹³⁸ once again attracting considerable publicity and interest from both within and outside the medical profession.

Unlike the founders of the original Euthanasia Society of America, neither Concern for Dying nor the Society for the Right to Die have openly advocated active voluntary euthanasia. They have, instead, focused their activities on recognition of the patient's right to refuse treatment, acceptance of living wills and matters generally falling within the category of 'passive' euthanasia. Although there was a marked difference in strategy between the two organisations in the late 1970s, by the end of the 1980s, both organisations had recognised the respective merits of educational and legislative initiatives in achieving their aims, and this was reflected in the diversification of their activities. This had, however, resulted in a duplication of programs and ineffective use of limited resources. In 1990, Concern for Dying and the Society for the Right to Die began negotiations for the merger of the two organisations and in September 1991 the two organisations merged to create a new organisation under the name Choice in Dying. The main advantages of the merger for both organisations is that it enables them to combine their resources and streamline duplicate programs, thereby creating a more efficient and influential organisation.¹³⁹

The Hemlock Society

In 1980 Derek Humphry, a journalist and author who had emigrated from England some two years earlier, and his second wife, Anne Wickett, established the Hemlock Society. In a media interview,¹⁴⁰ Humphry, long-time Executive Director of the society, explained that his motivation behind the formation of the society was the experience of helping his first wife, who was suffering from cancer, to commit suicide and later publishing a book on the subject entitled *Jean's Way*.¹⁴¹ According to Humphry, the experience of writing the book, and the reactions he received to it, got him caught up in the whole issue and led him to establish the Hemlock Society as a way to pursue the issue intelligently through research, writing and publishing books.¹⁴² The Hemlock Society derives its name from the root plant Hemlock, a poisonous umbelliferous plant. It was decided to use this name for the newly created organisation because of its connotations with rational suicide which the society supports.¹⁴³ Unlike the other societies in the United States which have limited their activities to the

¹³⁷ Society for the Right to Die (1985).

¹³⁸ S. Wanzel *et al.*, 'The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look' (1989) 320 *New Eng.J.Med.* 844.

¹³⁹ Note, 'Why Merger: The History and Reasons Behind the Decision' (1990) 17 *Concern for Dying Newsletter* 1, 5.

¹⁴⁰ *Medicine in the News* 2 April 1986.

¹⁴¹ (1978).

¹⁴² *Ibid.*

¹⁴³ Note, 'Q and A on the Hemlock Society' (1990) 37 *Hemlock Q.* 12.

pursuit of passive euthanasia, the Hemlock Society supports the option of active voluntary euthanasia for the terminally ill and has been the leading proponent of active voluntary euthanasia in North America. In 1981, the Hemlock Society was granted status as a non-profit, educational corporation, which means that all donations, gifts and legacies made to the society are tax deductible. This was a development of considerable practical significance, since the society is financially dependent on donations, as well as membership fees and the sale of its books.

Membership of the Hemlock Society has steadily grown since its establishment in 1980. As the influence and popularity of the Hemlock Society has increased, many chapters of the society have been set up throughout the United States. The Hemlock Society is a founder member of the World Federation of the Right to Die Societies. The stated principles of the society are to seek to promote a climate of public opinion which is tolerant of the right of people who are terminally ill to end their lives in a planned manner.¹⁴⁴ The Hemlock Society believes that the final decision to terminate life is ultimately one's own. It believes this action, and most of all its timing, to be an extremely personal decision, wherever possible taken in concert with family and friends. The society speaks only to those people who have mutual sympathy with its goals. However, views contrary to its own which are held by other religions and philosophies are respected.¹⁴⁵

Amongst the principal objectives of the society is the promotion of dialogue to raise public consciousness of active voluntary euthanasia through the news media, public meetings and with the medical and legal profession and others, and to support the principle of legislation to permit a dying person to lawfully request a doctor to help him or her to die.¹⁴⁶ In pursuit of its stated principles and objectives, the society engages in a wide range of activities. Its representatives, particularly Derek Humphry, founder and for many years Executive Director of the society, has developed a high profile with the media, frequently giving interviews as well as engaging in many television and radio debates with ethicists, doctors and lawyers throughout the country as well as abroad.¹⁴⁷ A quarterly newsletter¹⁴⁸ is issued to members, providing up to date information on issues of death and dying. The society also produces and distributes its own advance declaration.¹⁴⁹ The Hemlock Society is particularly notable for its numerous publications on suicide, assisted suicide, active voluntary euthanasia, and related issues.¹⁵⁰ It boasts many of its own titles, including the first United States

¹⁴⁴ The society does not encourage suicide for any primary emotional, traumatic, or financial reasons in the absence of terminal illness. It approves of the work of those involved in suicide prevention.

¹⁴⁵ See the statement of general principles in the society's literature, including in each issue of the newsletter, the *Hemlock Q*.

¹⁴⁶ *Hemlock Q*. (Permanent Supplement).

¹⁴⁷ R. Risley, *Death with Dignity* (1989) 74. Derek Humphry has recently resigned from his position as Executive Director.

¹⁴⁸ *Hemlock Q*.

¹⁴⁹ For detailed analysis of the Hemlock Society's version of the living will and how it compares with that distributed by the other organisations in the United States see R. Weir, *Abating Treatment with Critically Ill Patients* (1989) 183-184.

¹⁵⁰ Titles include D. Humphry, *Jean's Way* (1978); D. Humphry, *Let Me Die Before I Wake* (1981); D. Portwood, *Commonsense Suicide* (1983); G. Larue, *Euthanasia and Religion* (1985); D. Humphry and A. Wickett, *The Right to Die* (1986); D. Humphry, (ed.) *Compassionate Crimes, Broken Taboos* (1986); G. Johnson, *The Right to Die, Voluntary Euthanasia* (1987); R. Risley, *Death with Dignity* (1989); D. Humphry, *Final Exit* (1991).

guide to self-deliverance; *Let Me Die Before I Wake*, by Derek Humphry which was released in 1981. This book takes the form of case histories that illustrate the concept of active voluntary euthanasia. Thus, in the context of true stories of suicides by terminally ill people, lethal drug dosages are disclosed. The publication of this book caused considerable controversy, including condemnation from other voluntary euthanasia organisations in the United States, primarily on the grounds that such material is likely to be the subject of abuse.¹⁵¹ *Let Me Die Before I Wake* was initially only available to Hemlock members,¹⁵² but was subsequently released for general sale. It has proved to be the society's best selling title, with over 60,000 copies sold in the first five years of its release as well as reportedly being a heavily borrowed item in public libraries.¹⁵³ Humphry has since written another book on the subject, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* which has also proved to be enormously successful.¹⁵⁴ *Final Exit* is a detailed manual on how to commit suicide, explicitly setting out information about drug dosages, as well as giving guidance to doctors and nurses about helping people to die. As with the earlier publication *Let Me Die Before I Wake*, *Final Exit* has been the subject of controversy, primarily because of fears that it would be abused by people suffering depression or severe anxiety. The book was initially banned for sale in Australia on the grounds that it promoted assisting suicide (an offence in all Australian jurisdictions¹⁵⁵) but after widespread criticism,¹⁵⁶ this decision has been reversed.

In addition to its own publications, the society also sponsors a journal entitled the *Euthanasia Review* which publishes articles on a range of subjects connected with euthanasia.¹⁵⁷ A number of educational video programs on the subject of active voluntary euthanasia have also been produced by the society.¹⁵⁸ Since its inception in 1980, the society has sponsored a number of conferences on active voluntary euthanasia and related issues including the 7th biennial international conference of the World Federation of Right to Die Societies which was held in San Francisco in 1988.

Reflecting on the achievements of the society, Humphry has explained that the first five years of its work were devoted to raise public consciousness of the issue through its books, newsletters, conferences and media briefings.¹⁵⁹ By 1985, the view was taken by the representatives of the society that public support for active voluntary euthanasia was at a level sufficient to prompt legislative activities¹⁶⁰ and since then, the society has been pressing for legislation which would permit 'physician aid-in-dying'.¹⁶¹ In planning a strategy for legislative activity, it was decided to retain the

¹⁵¹ Humphry and Wickett, 122.

¹⁵² *Ibid.*

¹⁵³ *Id.* 183, 221.

¹⁵⁴ (1991) reported by *Publishers Weekly* to be a best selling non-fiction book and for some time held top position in the advice category of the *New York Times* best-seller list.

¹⁵⁵ See chapter III, 83-84

¹⁵⁶ See, for example, H. Kuhse, 'Editorial' (1992) Vol. 11 No. 3 *Bioethics News* 1-4.

¹⁵⁷ Edited by D. Humphry and A. Wickett.

¹⁵⁸ *A Time to Die* and *The Right to Choose to Die*. For further information see Hemlock Society's promotional literature.

¹⁵⁹ D. Humphry, 'Physicians and Euthanasia' (1988) 3 *Euthanasia Rev.* 79, 81-82.

¹⁶⁰ *Id.* 82.

¹⁶¹ See chapter VII, 339-343.

Hemlock Society as the intellectual underpinning of the movement, specialising as it does, in research and publication, and to start a new organisation which would have the appropriate legal status to substantially engage in active politics.¹⁶² The Hemlock Society provided financial support for the creation of a sister organisation¹⁶³ for the purpose of changing State law to permit physician-aid-in-dying for the terminally ill. The new organisation, Americans Against Human Suffering (A.A.H.S.) which was established in 1986, is the political arm of the Hemlock Society, with a different tax status which allows it to engage in law reform activities. In collaboration with A.A.H.S, the Hemlock Society has campaigned for the introduction of physician aid-in-dying legislation in a number of American States.¹⁶⁴

Canada

There are presently four voluntary euthanasia societies in Canada; Dying with Dignity; Goodbye, A Right to Die Society; The Right to Die Society of Canada; and Fondation Responsable Jusqu'a la fin, (Foundation Responsible Until the End). The largest of the organisations, Dying with Dignity established in 1980, is a national organisation based in Toronto, Ontario.¹⁶⁵ Notwithstanding its relatively short history, it has already made considerable progress in pursuing its objectives. In its promotional literature, Dying with Dignity describes itself as 'a Canadian society concerned with the quality of dying'. The stated aims of the society are to inform and educate Canadians about the right to a good death, to promote a better understanding among the general public and health care professionals regarding the issues of death and dying, to distribute and encourage recognition of the living will in Canada and to encourage medical and legal recognition of active voluntary euthanasia.¹⁶⁵ Dying with Dignity is a non-profit registered charitable organisation and donations to the society are consequently tax deductible.

Dying with Dignity engages in a wide range of activities in pursuit of its objectives. The society issues a quarterly newsletter, provides speakers for meetings, and offers its library resources to the public. Its staff, principally consisting of an Executive Director, supplemented by volunteer assistance, handle numerous telephone inquiries and letters¹⁶⁶ and also seek to provide a counselling service about options for the terminally ill.¹⁶⁷ In furtherance of its stated aims, the society is also involved in the promotion and distribution of its own living will and durable power of attorney and has endorsed legislative developments to give legal recognition to these forms of advance directive.¹⁶⁸

¹⁶² *Ibid.*

¹⁶³ At the Hemlock Society's 1986 Convention, Derek Humphry announced a grant of \$50,000 to establish Americans Against Human Suffering.

¹⁶⁴ For discussion of these legislative developments, see chap VII, 339-343.

¹⁶⁵ See Dying with Dignity pamphlet. (A statement of aims also appears in some of the newsletters.)

¹⁶⁶ (1989) Vol. 6 No. 1 *Dying with Dignity Newsletter* 8.

¹⁶⁷ Report of the Executive Director (1990) Vol. 7 No. 3. *Dying with Dignity Newsletter* 3.

¹⁶⁸ See chapter VII, 348.

In its efforts to educate Canadians about the right to a good death and to promote a better understanding among the general public and health care professionals regarding the issues of death and dying, the society has played an active role in the media. Representatives of the society are regularly invited to appear on radio and television interviews and talkback shows and frequently hold interviews with the print media.¹⁶⁹ Apart from its own media involvement, the society has been closely monitoring media coverage on the issue of euthanasia generally which it reports to members through its newsletter. Particularly in recent years, there has been a tremendous increase in the media attention on the subject of active voluntary euthanasia in Canada, generating and reflecting a lot of interest in the country about these issues.

Other educationally orientated activities organised by the society include a regular public forum on health care issues which attract considerable interest and are usually very well attended.¹⁷⁰ The society also sponsors other conferences, and in 1989 hosted the inaugural conference of the members of the World Federation of the Right to Die Societies located in the Western Hemisphere, a biennial event, to be held in the year between the World Federation meeting.¹⁷¹

Dying with Dignity has been actively fostering a co-operative working relationship with the medical profession in Canada.¹⁷² The society has established dialogue with a number of medical organisations and has conducted a number of surveys of doctors to gauge respondents' awareness of and attitudes to the living will, which have generally promoted a positive response from the doctors surveyed.¹⁷³ The extent of this co-operative relationship is reflected in the fact that the medical organisations have been co-sponsors of the public forums organised by the society which often feature speakers from the medical profession. The society has also been involved in various other initiatives intended to promote an appreciation of the role and aims of the society within the medical community.¹⁷⁴ In 1989, Dying with Dignity convened a special meeting of doctors and lawyers, with the aim of informally exchanging ideas on topics of mutual concern, including patients' rights within the health care system, medical and legal recognition of the living will and durable power of attorney for health care, and the need, if any, for protective legislation for doctors honouring the wish of a patient to die with dignity.¹⁷⁵ Further combined medico-legal initiatives are underway with the support of the society, to formulate legislation on the living will.

¹⁶⁹ Since 1988, the society's newsletter features a regular column detailing members involvement in the media.

¹⁷⁰ For example Public Forum 1987, (see Note, 'Choices: The Quality of Dying' (1988) Vol. 5 No. 1 *Dying with Dignity Newsletter* 4); Public Forum 1988, 'A Community Response to the Quality of Dying' (see Note, 'Forum, October 17, 1988' (1989) Vol. 6 No. 1 *Dying with Dignity Newsletter* 2), Public Forum 1989, 'No Heroics Please', (see Note, 'Listen to Patients Says Forum Speaker' (1990) Vol. 7 No. 1 *Dying with Dignity Newsletter* 2).

¹⁷¹ Note, 'A Good Turnout' (1989) Vol. 6 No. 3 *Dying with Dignity Newsletter* 2.

¹⁷² Note, 'Report on the 7th Biennial Conference of the World Federation of the Right-to-Die Societies' (1988) Vol. 5 No. 3 *Dying with Dignity Newsletter* 5.

¹⁷³ Note, 'Ontario Physicians Respond' (1987) Vol. 4 No. 4 *Dying with Dignity Newsletter* 1.

¹⁷⁴ For example, the society co-operated with a program on Dying with Dignity arranged by the Medico-Legal Society of Toronto; Note, 'Medico-Legal Society Learns About DWD' (1990) Vol. 7 No. 1 *Dying with Dignity Newsletter* 5.

¹⁷⁵ Note, 'Impressions of the Doctors/Lawyers Meeting' (1989) Vol. 6 No. 2 *Dying with Dignity Newsletter* 6.

Over its relatively short history, Dying with Dignity has enjoyed growing acceptance and support for its aims, evidenced by increasing membership, financial contributions, and attendance at meetings and public forums. However, there have, in the past, been complaints from some members on the grounds that the society was not sufficiently vocal or active in promoting the issue of active voluntary euthanasia. No doubt encouraged by evidence of growing community and professional support, there has, in recent years, been some reassessment of the society's policy position with regard to the issue of active voluntary euthanasia. This has resulted in a shift of emphasis in the aims and activities of the organisation, with a strengthening of the organisation's commitment to active voluntary euthanasia.¹⁷⁶ Active voluntary euthanasia is now more openly advocated and a voluntary euthanasia declaration has been prepared and distributed.¹⁷⁷ The society has also established a registry for the durable power of attorney for health care and the voluntary euthanasia declaration.¹⁷⁸

Membership in Dying with Dignity has been increasing steadily over recent years, much of which the society attributes to its media activities, as well as to a growing awareness in the community of the issues that it espouses.¹⁷⁹ The organisation also reports an increase in institutional membership which, it believes, reflects growing social acceptability of the organisation in Canada.¹⁸⁰ Dying with Dignity has established branches in a number of centres across Canada for the purpose of providing a closer contact for members in these communities.¹⁸¹ The national body provides resources to assist these groups in their operation. Dying with Dignity is the Canadian representative in the World Federation of the Right to Die Societies.

In the past few years a number of new right to die societies have been established in Canada. Goodbye, A Right to Die Society was established in March 1991. The aims of this organisation are to promote public awareness of the right to die with dignity, to disseminate information to the public and to advocate legislation which will allow individuals the freedom to choose to die with dignity and permit their doctors to assist in implementing their patients' choice. The society promotes the legalisation of active voluntary euthanasia and has an arrangement with the Hemlock Society enabling it to sell that society's books and pamphlets.¹⁸²

Another newly established society which also promotes the legalisation of active voluntary euthanasia is the Right to Die Society of Canada, a non-profit organisation which has its headquarters in Victoria, British Columbia. The Right to Die Society of Canada, established in 1991, is also in alliance with the Hemlock Society and sells the Hemlock Society's books and publications.¹⁸³

¹⁷⁶ (1989) Vol. 6 No. 1 *Dying with Dignity Newsletter* 5.

¹⁷⁷ Note, 'Voluntary Euthanasia Declaration' (1988) Vol. 5 No. 2 *Dying with Dignity Newsletter* 1.

¹⁷⁸ Report of the Executive Director (1988) Vol. 5 No. 3 *Dying with Dignity Newsletter* 4.

¹⁷⁹ Note, 'We Continue to Grow' (1990) Vol. 7 No. 2 *Dying with Dignity Newsletter* 3.

¹⁸⁰ Report of the Executive Director (1990) Vol. 7 No. 3 *Dying with Dignity Newsletter* 3.

¹⁸¹ Branches presently exist in Montreal, Ottawa, Toronto and London.

¹⁸² Goodbye, A Right to Die Society pamphlet.

¹⁸³ Right to Die Society of Canada pamphlet.

The fourth voluntary euthanasia society operating in Canada is Fondation Responsable Jusqu'a la fin (Foundation Responsible Until the End), based in Neufchatel, Quebec. The principal aim of this organisation which was established in 1986, is to promote the right to die in accordance with the existing laws in the Province of Quebec and to secure recognition of the living will. The Foundation does not promote active voluntary euthanasia.¹⁸⁴

International Developments: The World Federation of Right to Die Societies

The first international meeting on voluntary euthanasia was held in Tokyo in 1976 followed by a meeting in San Francisco in 1978. As a result of these early meetings, the World Federation of Right to Die Societies was founded in Oxford, 1980, with 27 groups from eighteen countries joining as founding members. Whilst there have been some fluctuations, membership in the federation has remained fairly constant and presently stands at 30 with representation from most voluntary euthanasia organisations throughout the world.¹⁸⁵ The World Federation of Right to Die Societies, deliberately named in such a way that it would cover all voluntary euthanasia and right to die societies - whether proponents of passive and or active euthanasia, aim to establish voluntary euthanasia organisations in every country and to secure throughout the world, the legalisation of the right of self-determination in dying.¹⁸⁶ As a federation, its major role is the co-ordination on an international basis of the member societies.¹⁸⁷ Its major organisational activity is the biennial meeting held in connection with the biennial international euthanasia conference. These conferences, hosted by members of the federation, have been held in Melbourne (1982), Nice (1984), Bombay (1986), Los Angeles (1988), and Maastricht (1990) and Kyoto (1992). The meeting of representatives of the member societies at the international conferences is regarded as invaluable, offering the opportunity for reporting of news from each member society and acting as a medium for dialogue and exchanging ideas among member organisations. The federation publishes a World Right to Die Newsletter twice a year. Under the World Federation's Constitution, its affairs are to be managed by its Board of Directors. The Board of Directors has recently been enlarged from 8 to 10 people,¹⁸⁸ and consists of a President, Vice President, Secretary, Newsletter Editor and Treasurer plus five Directors at large. The current President is Jean Davies, (former President of the Voluntary Euthanasia Society, London) replacing Derek Humphry. Other positions are held by individuals from a number of jurisdictions, including Australia, New Zealand, the United States and Canada.¹⁸⁹

¹⁸⁴ Fondation Responsable Jusqu'a la fin pamphlet.

¹⁸⁵ See Note, 'Profiles of World Federation of Right to Die Societies Members' (1989) 15 *World Right-to-Die Newsletter* 2-5.

¹⁸⁶ See the By-Law of World Federation of Right to Die Societies, Article II setting out the purposes of the World Federation.

¹⁸⁷ *Ibid.*

¹⁸⁸ Note, 'Federation Developments - 1976 to the Present' (1990) 16 *World Right-to-Die Newsletter* 3.

¹⁸⁹ *Id.* 1, 3. Dr Helga Kuhse, Director of the Monash Center for Human Bioethics, Victoria is a Director; Frank Dungey, Honorary Secretary of the Voluntary Euthanasia Society, Wellington holds position as Secretary; Derek Humphry, former Executive Director of the Hemlock Society, is a Director; and Marilynne Seguin, Executive Director of Dying with Dignity, Canada was, for a number of years, the Editor.

As a world federation, the various member societies are able to present a unified policy position on particular issues, in circumstances where a co-ordinated international approach is required. A good example is the federation's submission to the Human Rights Commission of the United Nations. This initiative emerged from the 8th conference of the World Federation of Right to Die Societies held in 1988. Dr Helga Kuhse of Australia, philosopher and well-known active voluntary euthanasia advocate, undertook the task of preparing the statement on behalf of the federation. In the spirit of compromise, it was agreed that the submission be confined to passive euthanasia, so that the views of all member societies could be represented.¹⁹⁰ The object of this submission was for the incorporation of the Right of Dying with Dignity as an Appendix to the Charter of Human Rights of 1948 in the hope that the United Nations would subsequently encourage its member countries to introduce suitably reformed laws which affirm the patients' right to die with dignity.¹⁹¹

Voluntary Euthanasia Societies: A Global Perspective

It is evident from the foregoing review that in the past few decades there have been significant developments in the voluntary euthanasia movement with the emergence and expansion of voluntary euthanasia societies in Australia, New Zealand, the United Kingdom, the United States and Canada. The developments in these jurisdictions have been paralleled by similar developments in other parts of the world.¹⁹² In the jurisdictions under consideration, most of the voluntary euthanasia organisations have as their aim the legalisation of active voluntary euthanasia although there are a number of organisations in the United States whose objectives are confined to legalisation of passive euthanasia and the right of an individual to die with dignity.¹⁹³ Virtually all of the societies report steadily increasing membership and growing community support and acceptance of their cause. There is a widely held view amongst members and supporters of these societies that this is a movement 'whose time has come'.¹⁹⁴ This in turn has been reflected in increased reform activity, with ongoing initiatives in a number of jurisdictions for the introduction of legislation permitting active voluntary euthanasia. Although the voluntary euthanasia societies in Australia and New Zealand are of fairly recent origin in comparison with other jurisdictions such as the United Kingdom and the United States, they are fairly forthright in their aim of promoting legislation which permits active voluntary euthanasia. To date their activities have primarily been focused on increasing community awareness and acceptance of active voluntary euthanasia, but in more recent years there has been some shift towards more direct efforts to introduce legislative reforms.

¹⁹⁰ Note, 'World Federation Submission to United Nations' (1988) Vol. 5 No. 2 *Dying with Dignity Newsletter* 1.

¹⁹¹ Note, 'Following Up on the World Federation's Statement to the United Nations' (1988) 13 *World Right-to-Die Newsletter* 1.

¹⁹² For coverage of international developments generally see the *World Right-to-Die Newsletter*.

¹⁹³ Choice in Dying (formerly 'Society for the Right to Die' and 'Concern for Dying').

¹⁹⁴ For example, Note, 'Voluntary Euthanasia - An Idea Whose Time Has Come' (1990) 70 *V.E.S.V. Report* 1-2; Note, 'Now is the Time' (1990) Vol. 7 No. 1 *Dying with Dignity Newsletter* 7; Note, 'Voluntary Euthanasia is 'an Idea Whose Time Has Come' Says Derek Humphry' (1992) 78 *V.E.S.V. Report* 3.

Another factor contributing to the public awareness and acceptance of active voluntary euthanasia is the substantial increase in media coverage of the issue in the form of radio and television programs and press reports.¹⁹⁵ Not only has there been a significant increase in the extent of the media coverage but there appears also to be growing sympathy in the media's treatment of the subject.¹⁹⁶ The publicity surrounding the issue of active voluntary euthanasia and the public interest in the subject has been stimulated by a variety of items regularly presented through the media, including coverage of reform initiatives,¹⁹⁷ reports of increasingly favourable opinion poll results, frequent claims in the media that active euthanasia is already being practiced by some doctors,¹⁹⁸ accounts of poignant pleas for legalised active voluntary euthanasia by the sick and elderly,¹⁹⁹ and reports of heart-rending cases before the courts involving family 'mercy killings'.²⁰⁰ Widespread publicity and concern about the AIDS epidemic has also contributed to the momentum of the voluntary euthanasia movement, with media reports of AIDS sufferers seeking active euthanasia accompanied by claims that these requests are generally dealt with sympathetically by the medical profession.²⁰¹

Over the years, the voluntary euthanasia cause has also been promoted by prominent public figures who have indicated their support for the legalisation of active voluntary euthanasia. For example, in 1988 the acclaimed Australian author, Kylie Tennant whilst suffering from terminal cancer, made an impassioned plea for the legalisation of active voluntary euthanasia in Australia. In the much publicised 'last letter to a friend,' she expressed a desire to be allowed to die with dignity and urged all Australians to do what they can to bring about change in this area.²⁰² Other prominent Australian public figures to endorse active voluntary euthanasia have been Sir Mark Oliphant, well-known scientist and patron of the South Australian Voluntary Euthanasia Society,²⁰³ and Justice Michael Kirby, former chairman of the Australian Law Reform Commission and a frequent advocate of reform in this area.²⁰⁴ Much publicised support for the voluntary euthanasia cause in Australia was also

¹⁹⁵ See also Russell, 194-195 commenting on the position in the United States.

¹⁹⁶ This is exemplified by an editorial in *The Times*, 'Rights and Wrongs of Dying' 28 Oct. 1991 which suggested that the issue of active voluntary euthanasia should not be left unresolved indefinitely and that it should be the subject of a full-scale public inquiry. More recently, in response to the conviction of Dr Cox in the United Kingdom, (discussed in chapter IV, 126-127) there were a number of newspaper items which dealt with the case very sympathetically; see, for example, the *Sunday Telegraph* 20 Sept. 1992; *The Times* 21 Sept. 1992; the *Guardian* 22 Sept. 1992; *Daily Express* 23 Sept. 1992.

¹⁹⁷ For discussion or reform developments, see chapter VII.

¹⁹⁸ For example, through reports on surveys of the medical profession (e.g. 'Doctors in Survey Back Euthanasia' the *Age* 5 March 1988) and admissions by individual doctors. ('Doctor Says he Helped Terminal Patients to Die' the *Mercury* 9 March 1992). There have also been some interesting historical claims which have emerged only relatively recently, of active euthanasia having been practiced on members of the British Royal family, namely, King George V (the *Bulletin* 9 Dec. 1986) and Queen Mary (the *Mercury* 18 Oct. 1990).

¹⁹⁹ For example, the letter published in the *Australian* 13 July 1988 from Mrs Fenakel to the then New South Wales Premier, Mr Griener.

²⁰⁰ See chapter IV, 129-146.

²⁰¹ For example, *Sydney Morning Herald* 5 April 1987 and the *Australian* 7 April 1987.

²⁰² *Sydney Morning Herald* 6 Feb. 1988.

²⁰³ Note, 'Our Front Cover' (1990) Vol. 7 No. 3. *S.A.V.E.S.Bull.* 7.

²⁰⁴ His publications include 'The Right to Live and the Right to Die' (1983) 57 *Law Inst.J.* 1192; 'Euthanasia - Old Issue; New Debate' (1984) 14 *A.&N.Z.J. Med.* 691.

forthcoming from Ian Temby Q.C., in a paper presented to the Australian Academy of Forensic Sciences during his term as Commonwealth Director of Public Prosecutions.²⁰⁵

Similarly, in other jurisdictions, the voluntary euthanasia movement has been fuelled by statements of support from well-known figures. For example, in the United Kingdom, the acclaimed writer Arthur Koestler did much to contribute to public awareness and acceptance of active voluntary euthanasia through his support of the British Voluntary Euthanasia Society,²⁰⁶ and through his much publicised suicide pact with his wife after he became incurably ill with Parkinson's disease and leukemia.²⁰⁷ Numerous other prominent figures have over recent years indicated their support for the voluntary euthanasia cause, including Katherine Hepburn²⁰⁸ and Dirk Bogarde.²⁰⁹

To some extent the discernible increase in media coverage of the issue of active voluntary euthanasia in recent years is a reflection of changing community attitudes on the issue, and the media is quite naturally tapping into an increasingly interested market. However, the media also plays a role in informing and shaping public opinion and there can be little doubt that extensive media coverage of the issue, particularly with a pro-euthanasia slant, is a significant contributing factor in the changing climate for reform.

Organised Opposition to the Legalisation of Active Voluntary Euthanasia

While the voluntary euthanasia movement has clearly been advancing, so has the opposition to euthanasia from certain groups.²¹⁰ Since the commencement of the modern voluntary euthanasia movement, any public support for euthanasia, and attempts to introduce legislative reform have invariably attracted protest from certain sources. Anti-euthanasia sentiment was particularly strong in the 1950s, attributable at least in part, to the revulsion to the Nazi crimes.²¹¹

As previously noted,²¹² the churches, especially the Roman Catholic Church, have traditionally been opposed to the notion of active voluntary euthanasia, and have, particularly during the early 1950s, been quite vocal in their condemnation of any proposals for its legalisation.²¹³ Notwithstanding the churches' opposition, there have always been individual dissenters who have been willing to publicly

²⁰⁵ 'Euthanasia - Is it Murder' presented in Sydney, 19 July 1988 and published in the Australian Journal of Forensic Sciences; (1988) 21 A.J.F.S. 2.

²⁰⁶ Koestler was for a time Vice-Chairman of the Society and had written the preface to the society's booklet, *A Guide to Self-Deliverance*.

²⁰⁷ *Time* 21 March 1983.

²⁰⁸ *Sun/Telegraph* 30 Aug. 1987.

²⁰⁹ Note, 'The Right to Die With Dignity' (1991) 43 V.E.S. Newsletter 2.

²¹⁰ For historical coverage of the opposition to euthanasia, see Russell, 59-214; Wilson, 28-45; Humphry and Wickett, 14-136.

²¹¹ Russell, 104; van der Sluis, 161.

²¹² See chapter V, 197-199.

²¹³ Russell, 109, 200.

indicate their support for legalisation.²¹⁴ However, even the churches themselves have, in more recent times, indicated a willingness to re-examine traditional views pertaining to life and death.²¹⁵ Some churches have, for example, introduced their own initiatives to examine the problems associated with death and dying, including the issue of euthanasia.²¹⁶ Since the mid 1960s, there has been increasing discussion of the issue of euthanasia in church sponsored periodicals including articles openly supporting active voluntary euthanasia.²¹⁷ Today, the churches have generally come to accept the practice of passive euthanasia, in recognition of the problems associated with medical advancements and the futile prolongation of life.²¹⁸ Support has also been given to the practice of administering to a dying person drugs for the alleviation of pain, even though they may hasten death.²¹⁹ More significantly, there has even been support for active voluntary euthanasia, at least in some circumstances, from a number of notable Catholic and Protestant theologians.²²⁰ In recent years, there have been quite a number of ordained clergy from a broad spectrum of denominations who have indicated their support for active voluntary euthanasia.²²¹

In addition to the traditional opposition from the churches, right to life groups have also been vocal opponents of euthanasia.²²² Alongside their campaign efforts to prohibit abortion, right to life organisations have vigorously opposed any legislative proposals for the legalisation of active voluntary euthanasia, and even 'natural death' and 'living will' legislation which permits only passive euthanasia in some limited circumstances has attracted opposition.²²³ Whilst upholding the general right of patients to control their own treatment, right to life organisations are opposed to any

²¹⁴ For example, Sullivan, 19-21.

²¹⁵ Russell, 200-214.

²¹⁶ For example the Church of England, National Assembly Board for Social Responsibility established an inquiry and in 1965 published a report entitled, *Decisions about Life and Death*. See also the Church Assembly Board for Social Responsibility, *On Dying Well* (1975).

²¹⁷ Russell, 209.

²¹⁸ *Id.* 202- 206. Note, however, resistance is sometimes encountered to the use of the word euthanasia. For further discussion, see the Introduction to this thesis, 3-5.

²¹⁹ *Id.* 205. With specific reference to the Catholic Church, see Pope Pious XII, 'Religious and Moral Aspects of Pain Prevention in Medical Practice' (1957) 88 *Ir. Ecclesiastical Rec.* 193.

²²⁰ For example, D. Maguire, (Professor of Theology); R. McCormick, (Catholic moral theologian); P. Ramsey, (Protestant Minister, Professor of Religion). For reference to the views of these commentators see chapter V.

²²¹ For two recent Australian examples, note Reverend John Best, retired Anglican priest who was, until his recent death, Vice-President of the Western Australian Voluntary Euthanasia Society (see Note, 'Cleric Campaigns for Euthanasia' (1991) Vol. 11 No. 4 *W.A.V.E.S. News* 6); and Mr Kenneth Ralph, Minister of the Uniting Church in Australia (see K. Ralph, 'Religious Dimensions to Voluntary Euthanasia' (1992) 76 *V.E.S.V. Report* 1). There have been similar reports in the United Kingdom; see, for example, Note, 'Support from Bishop of Durham' (1992) 46 *V.E.S. Newsletter* 3. There was also considerable support from the clergy for 'Initiative 119', the proposal to introduce physician aid-in-dying legislation in Washington State; see Note, 'Clergy for Voluntary Euthanasia' (1992) Vol. 11 No. 1 *Bioethics News* 4. See chapter VII, 342.

²²² In Australia there are two national right to life organisations; Right to Life Australia, (a national organisation with State branches), and the Australian Federation of Right to Life Associations which is an affiliation of State right to life bodies. For general coverage of the right to life viewpoint (particularly in the United States) see Humphry and Wickett, 170-178.

²²³ In Australia, efforts to introduce refusal of treatment legislation in Victoria and natural death legislation in Tasmania, met with concerted opposition from right to life groups. Similar resistance has been encountered in the United States with regard to 'living will' and euthanasia legislation; see Humphry and Wickett, 172. (For further discussion of these legislative developments, see chapter VII.) In the United Kingdom, right to life societies emerged in response to the concerted efforts of the Euthanasia Society in England in 1969 to enact voluntary euthanasia legislation; Russell, 186.

deliberate termination of life; whether by passive or active means.²²⁴ As the voluntary euthanasia movement has gained in intensity, a number of new organisations have been established for the purpose of counteracting this development and fighting against the legalisation of active voluntary euthanasia.²²⁵ For example, in 1987, the International Anti-Euthanasia Task Force was established in the United States, which has, as its stated purpose, *inter alia*, to promote and defend the right of all persons to be treated with respect, dignity and compassion and to resist attitudes, programs and policies which threaten the lives and rights of those who are medically vulnerable.²²⁶ In the United Kingdom a new organisation was established in 1991 under the name of ALERT which aims to campaign against the legalisation of active voluntary euthanasia. ALERT issues a regular newsletter²²⁷ and is affiliated with the International Anti-Euthanasia Task Force.

These anti-euthanasia developments can be seen as a direct response to the modern voluntary euthanasia movement and to the growing success of the campaign for the legalisation of active voluntary euthanasia.

PART III

Signs of Change from Within the Medical Profession

As noted earlier, although passive euthanasia is now widely accepted as an appropriate form of medical practice, the medical profession has traditionally been opposed to the concept of active voluntary euthanasia and has steadfastly resisted efforts to secure its legalisation.²²⁸ However, notwithstanding the medical profession's traditional opposition to active voluntary euthanasia, some prominent and respected doctors have openly supported the voluntary euthanasia cause and have in fact played a significant role in the establishment and development of the voluntary euthanasia movement.²²⁹ Developments within the medical profession in more recent years indicate that professional medical organisations need to re-examine their official stance on the issue of active voluntary euthanasia. Not only are there continuing reports of some more outspoken members of the profession indicating their support for legalisation of the practice,²³⁰ there is also growing evidence to suggest that attitudes to the issue of active voluntary euthanasia have undergone considerable change within the profession generally. Reliable surveys of the medical profession conducted in Australia and other jurisdictions have shown that a substantial proportion of doctors are in favour of the legalisation of active

²²⁴ See generally right to life literature; e.g. pamphlet 'What is Pro-Life Victoria?'

²²⁵ Note also the World Federation of Doctors Who Respect Human Life, which publishes a monthly newsletter, entitled *News Exchange*.

²²⁶ See pamphlet, International Anti-Euthanasia Task Force, Human Life Center, University of Steubenville.

²²⁷ ALERT *Euthanasia Update*.

²²⁸ See chapter IV, 112-113

²²⁹ See above, 243-244 for discussion regarding the establishment of the V.E.S. U.K.. For detailed historical coverage of the position in the United States and the United Kingdom, see Russel, chapters 4-7; Humphry and Wickett, chapters 1-7.

²³⁰ For example, Dr Rodney Syme (see below, 270) and Dr Timothy Quill, (see below, 287).

voluntary euthanasia, and have indicated that they would be willing to engage in the practice if it were made legal. In the light of this evidence, it is becoming increasingly evident that the professional medical associations no longer represent the views of their members on this issue and that a major reassessment of the associations' traditional opposition to active voluntary euthanasia is now long overdue.

Some progress towards reform has already been made at the official levels of the medical profession. The widespread acceptance of medical conduct which involves passive euthanasia as being consistent with legitimate medical practice can be seen as a step towards the reform of the law with regard to active voluntary euthanasia.²³¹ The practical endorsement of passive euthanasia by the medical profession does, to a large extent, reflect growing recognition of the practical limits of modern medical technology and of the importance of patient autonomy and self-determination in deciding upon treatment choices. As argued in an earlier chapter,²³² these principles apply with equal force to active voluntary euthanasia so the foundation has been laid for broader recognition of patients' rights in this area.

There are also other indications that the medical profession may, in the longer term, be amenable to reform on the issue of active voluntary euthanasia. In recent years, there appears to be greater willingness on the part of the profession to re-evaluate its stance with regard to active voluntary euthanasia and openly debate the issues involved. This is clearly evidenced by the increased attention to the issue of active euthanasia in the medical literature,²³³ as well as the growing number of medical conferences, symposia, seminars, and meetings where the issue has been discussed. Further, in a number of jurisdictions, medical associations have actually initiated inquiries to reassess their traditional opposition to the legalisation of active voluntary euthanasia.²³⁴ The significance of these developments must be considered against the traditionally accepted view that active euthanasia is no part of the work of doctors and the resulting sensitivity of the medical profession in broaching this subject.

There have also been a number of other factors operating within the medical profession which have, in a more general way, contributed in the process of reform towards recognition of active voluntary euthanasia. One such factor is the increasing attention being given to the subject of medical ethics generally. Over the past ten years or so, quite a number of research centres and institutions have been established in Australia (and other jurisdictions) devoted to teaching and research in this field,²³⁵ and

²³¹ This proposition derives support from but does not depend on the 'moral equivalence argument' discussed in chapter V, 181-183. It should be noted, however, that members of the medical profession may object to the use of the term 'passive euthanasia' to describe the withholding or withdrawing of treatment. (See the Introduction to this thesis, 5.)

²³² See chapter V, 179-183.

²³³ Russel, 119-123, 139.

²³⁴ For discussion of the S.A. branch of the A.M.A. and the B.M.A. working parties on euthanasia, see below, 268-269 and 273-279 respectively.

²³⁵ For example in Australia, the establishment of the Monash Centre for Human Bioethics; in the United States, the Kennedy Institute of Ethics at Georgetown University, Washington and the Hastings

institutional ethics committees have also come into prominence. Growing recognition of the importance of medical ethics has resulted in a reassessment of medical curricula in most jurisdictions to include some teaching of medical ethics.²³⁶ The significance of these developments with regard to active voluntary euthanasia has been its effect in stimulating debate on the issue within the medical profession.

Another development within the medical profession, which has indirectly assisted the voluntary euthanasia cause has been growing attention to the needs of the dying, embracing not only medical matters but also the emotional and psychological needs of terminal patients. Though previously a much neglected area, since the 1960s, there has been a significant upsurge in research and interest on this subject. The practical limits of modern medical technology are increasingly being recognised, and there has been a recasting of priorities from attempting to preserve life at all cost to easing the passing of dying patients. This development has been manifest in a number of ways, including an outpouring of literature on the subject of death and dying,²³⁷ increasing attention to the subject in the medical curriculum, growing recognition of the importance of appropriate pain control for terminal patients, and the development of hospice and palliative care facilities. Whilst these factors do not of themselves necessarily point to the acceptance of legalised active voluntary euthanasia, they have, nevertheless, been of relevance to the voluntary euthanasia cause in that they reflect a changed attitude within the medical profession to the needs of the dying.

It should be noted, however, that although there has been a shift towards greater understanding and acceptance of active voluntary euthanasia within the medical profession, there have also been elements within the profession which remain steadfastly opposed to the concept and have vigorously countered any proposals for the legalisation of active voluntary euthanasia.²³⁸

Separate consideration will now be given to the position in Australia and to the main aspects of change in the United Kingdom and the United States.

Center, New York; in the United Kingdom the Institute of Medical Ethics; and in Canada, the Center for Bioethics, Clinical Research Institute of Montreal.

²³⁶ According to a survey conducted by the Rev. Dr John Morgan, all medical schools in Australia have made ethics a compulsory part of the curriculum; *Sydney Morning Herald* 9 Jan. 1991. For literature reflecting the changing approach of the medical profession to the teaching of medical ethics, see D. Chambers, 'Ethics or Medical Ethics' (1984) 24 *Med. Science & Law* 17 and the *Report of a Working Party on the Teaching of Medical Ethics* (The Pond Report) (1987).

²³⁷ For example, E. Kubler-Ross, *On Death and Dying* (1969); J. Hinton, *Dying* (1967). For more detailed consideration of the increased attention to the subject of death and dying, see Humphry and Wickett, 68-84; Russel, 168-175.

²³⁸ For example, in Australia, Dr Brian Pollard, who has published quite a number of articles arguing the case against active voluntary euthanasia, and has published a book entitled *Euthanasia* (1989). At the international level, an organisation of doctors has been established (World Federation of Doctors who Respect Human Life) to prevent the legalisation of active voluntary euthanasia.

The Australian Medical Association (A.M.A.) is the largest medical association in Australia.²³⁹ As noted earlier, the official position of the A.M.A with regard to active voluntary euthanasia has always been one of opposition.²⁴⁰ However, recent events in Australia indicate that in adopting this position, the association may not be reflecting the views of its members, nor of doctors generally in Australia.

Whilst there have, from time to time, been expressions of support for active voluntary euthanasia from members of the medical profession in Australia,²⁴¹ by far the most significant development in recent years has been the evidence of attitudes and practices of Australian doctors revealed in surveys of the medical profession undertaken in Victoria and South Australia. The first and most comprehensive survey to be undertaken was the 1987 survey of attitudes and practices of doctors in Victoria, conducted by the Monash Centre for Human Bioethics.²⁴² In an earlier chapter, it has already been noted that one of the survey questions sought to ascertain the proportion of doctors who have taken active steps at the patient's request to hasten his or her death.²⁴³ Those doctors who had indicated that they had never taken active steps to bring about the death of a patient at his or her request were asked if they had rejected the request solely, primarily, or in part because it would have been illegal to act upon it. The responses indicated that the illegality was a factor in the rejection of the request with 65% of the doctors; 5% indicated that they rejected the request solely on this ground; and a further 15% said that they rejected the request primarily for this reason, leaving 45% of doctors for whom illegality was 'in part' a reason for the rejection of the request. For 35% of the doctors, it was not a reason at all.²⁴⁴

Another of the survey questions was directed at ascertaining doctors' attitudes to taking active steps to bring about a patient's death. Respondents were asked: 'Do you think that it is sometimes right for a doctor to take active steps to bring about the death of a patient who has requested the doctor to do this?' Of those surveyed, 62% believed that this was sometimes right, whilst 34% thought that it was not. Support for a doctor to take active steps came from doctors in all age groups but was greatest among the younger doctors. There was also majority support amongst most religious groups except Roman Catholics. Doctors who were members of the A.M.A. tended to have similar views to doctors

²³⁹ There are approximately 40,000 doctors in Australia of whom approximately 20,000 belong to the A.M.A. The other main medical associations in Australia are the Royal Australian College of General Practitioners (with a membership of approximately 7,000), the Royal Australasian College of Surgeons (5,000) and the Royal Australasian College of Physicians (4,000).

²⁴⁰ See above, 261.

²⁴¹ For example, Dr John Woolnough (see the *Australian* 22 June 1973); Dr Malcolm Parker, President of the Queensland Voluntary Euthanasia Society; see M. Parker, 'Moral Intuition, Good Deaths and Ordinary Medical Practitioners' (1990) 16 *J. Med. Ethics* 28; J. Ellard, 'Euthanasia and the Death of Freud' (1990) *Mod. Med. Aust.* (May) 14; R. Syme, 'A Patient's Right to a Good Death' (1991) 154 *M.J.A.* 203.

²⁴² H. Kuhse and P. Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 *M.J.A.* 623. Information regarding the survey methodology has been set out in chapter IV, 115.

²⁴³ See chapter IV, 115-116.

²⁴⁴ Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 623.

as a whole. Sixty-four percent of doctors who were members of the A.M.A. were of the view that it was sometimes right for a doctor to take active steps to bring about the death of a patient at his or her request compared with 62% of doctors who were not members of the association.²⁴⁵

The survey also sought to ascertain doctors' views of the Netherlands situation. Following a brief description of the situation existing in the Netherlands doctors were asked: 'Do you think it would be a good thing if such a situation were to exist in Australia?' More than half of the doctors indicated that they did think that it would be a good thing - 59% compared with 37% who answered no to this question. In order to determine doctors' attitudes to the position taken by their professional organisation, doctors were asked a further question: 'The Royal Dutch Medical Association believes that it is proper for doctors to take active steps to bring about a patient's death under the above circumstances. Do you think your professional organisation should take a similar stand?' Of those surveyed, 52% of doctors thought that their professional organisation should take a similar stand to that of the Royal Dutch Medical Association, whilst 43% of doctors did not think so. Although this question referred generally to the doctors' 'professional organisation', the only professional association that was mentioned in sufficient numbers in the responses to provide useful data was the A.M.A.²⁴⁶ Analysis of results on the basis of A.M.A. membership yielded similar results: 52% of doctors who were members thought that the A.M.A. should change its stance on this issue whilst 47% did not think so.²⁴⁷

Another of the survey questions focussed on the desirability of law reform. Respondents were asked: 'Do you think that the law should be changed to allow doctors to take active steps to bring about a patient's death under some circumstances?' Responses to this question were consistent with the similar question that was asked about the desirability of introducing into Australia a situation such as that which exists in the Netherlands. Sixty per cent of the respondents answered yes, 37% answered no.²⁴⁸ When asked whether they would practice active voluntary euthanasia if it were legal, 40% of the doctors said that they would, 41% said that they would not and the remainder did not answer this question.²⁴⁹

The authors of this survey regarding the practices and attitudes of Victorian doctors on the subject of active voluntary euthanasia have also completed a related survey to gauge the attitudes and practices of nurses in Victoria.²⁵⁰ The results of the survey of Victorian nurses, based on a questionnaire sent to 2,000 respondents, are generally consistent with the findings of doctors' practices and attitudes, indicating even stronger support for active voluntary euthanasia among nurses.²⁵¹ This suggests that

²⁴⁵ *Id.* 625, Table 2.

²⁴⁶ Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 624.

²⁴⁷ *Id.* 625.

²⁴⁸ *Ibid.*

²⁴⁹ Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 625.

²⁵⁰ Kuhse and Singer, 'Euthanasia: A Survey of Nurses' Attitudes and Practices'.

²⁵¹ Seventy-five percent of the nurse respondents (compared with 60% of the doctors in the earlier survey) supported the introduction in Australia of legalised active voluntary euthanasia under conditions like those in the Netherlands. Similarly, 68% of nurses, in comparison to 40% of doctors, were willing to

the evidence of support for active voluntary euthanasia amongst doctors is part of a broader trend towards recognition amongst health care professionals and the community generally.

The results of the Monash survey have since been confirmed in a number of surveys conducted in South Australia. In 1989 a study was conducted at the Flinders Medical Centre in South Australia, with the aim of generating results which could then be compared with those found by Kuhse and Singer in their survey of Victorian doctors.²⁵² The survey questions were closely modelled on the Victorian questionnaire and were distributed amongst doctors and medical students at the Flinders Medical Centre. Although there are some significant differences between the two surveys,²⁵³ the results obtained from the Flinders Medical Centre survey support the findings of Kuhse and Singer. For example, in response to the question: 'Do you think that it is ever right for a doctor to take active steps to bring about the death of a patient who has requested the doctor to do this?' 70% of the respondents answered yes compared with 62% of respondents in the Victorian survey.²⁵⁴ Similar results were also obtained with regard to the question aimed at ascertaining whether respondents considered that the situation in the Netherlands should be introduced in South Australia: 65% answered yes; 31% answered no; and 4% were unsure.²⁵⁵ This compared with a response rate of 59% of doctors in favour, 37% against, in relation to an equivalent question in the Victorian survey.

Another survey has recently been conducted in South Australia to ascertain the views of South Australian doctors on assisted dying.²⁵⁶ The findings of this survey, based on a sample of 1,000 South Australian doctors, has also tended to confirm the results of the more extensive Monash survey. Sixty-one percent of the respondent doctors were of the view that it is sometimes right for a doctor to take active steps to bring about the death of a terminally ill or incurable patient who has requested the doctor to do this. Over half of the respondent doctors (56%) indicated that they would like to see a law introduced based on the judicial guidelines allowing actively assisted dying in the Netherlands. Approximately half of the respondent doctors (48%) indicated that they would be prepared to actively assist an incurably ill patient to die if they were asked by the patient and the law permitted it.

Although these surveys have been confined to Victoria and South Australia, there is no reason to suggest that the responses from the doctors in these States, randomly selected, would not be broadly

be involved in the practice of voluntary euthanasia; Kuhse and Singer, 'Euthanasia: A Survey of Nurses' Attitudes and Practices,' 22. The authors suggest that the greater support for active voluntary euthanasia among nurses may reflect the closer relationship they often form with incurably ill patients and the resultant understanding of the patients' plight.

²⁵² T. Robertson and S. Tobin, 'A Survey of the Attitudes of Doctors and Medical Students Towards Active Voluntary Euthanasia' (unpublished manuscript, Flinders Medical Centre 1989).

²⁵³ Kuhse and Singer surveyed a random sample of 2,000 doctors throughout Victoria whilst in the Flinders Medical Centre survey, doctors and medical students were surveyed within one South Australian hospital. The Flinders Medical Centre survey also involved a much smaller sample covering all first year medical students (65 students), all fifth year medical students (55 students), all Flinders Medical Centre interns (31 interns) and one third of all Flinders Medical Centre doctors (90 doctors from a possible 268) totalling 241 persons surveyed. See Robertson and Tobin, 31.

²⁵⁴ Robertson and Tobin, 35, 53-54.

²⁵⁵ *Id.* 35-37, 55.

²⁵⁶ Medical Practitioners Concerned with Assisted Dying, Media Release, 'South Australian Doctors Help Incurable Patients to Die' 28 July 1992.

representative of the views of doctors generally in Australia. The overwhelming conclusion to be drawn from these surveys is that the majority of doctors support active voluntary euthanasia.²⁵⁷ This is consistent with the views of the public generally, although the level of support is slightly less amongst the medical profession.²⁵⁸ The authors of the Victorian survey, Dr Helga Kuhse and Professor Peter Singer, found it particularly noteworthy that, notwithstanding the present illegality of active voluntary euthanasia, some doctors were prepared to admit that they had taken active steps to hasten death at the request of the patient and that they believed that they were right to do so.²⁵⁹ The preparedness of doctors to make such admissions may in part be due to increasing community support for active voluntary euthanasia. Even more remarkable was the fact that nearly half of those who made such admissions signed the questionnaire, and did not avail themselves of the opportunity to respond anonymously.²⁶⁰ This was also the case in the survey of South Australian doctors:²⁶¹ 19 of the 43 doctors who acknowledged taking active steps to bring about the death of a patient who requested it identified themselves to the group carrying out the survey. This suggests a significant level of commitment to their decision to assist patients by performing active voluntary euthanasia at the patient's request. Furthermore, for the majority of the Victorian doctors who indicated that they had rejected a request for active voluntary euthanasia, the present illegality of the practice was stated to be at least 'in part' a reason for the rejection.²⁶² This clearly suggests that more doctors would be willing to perform active voluntary euthanasia if it were legal - a conclusion borne out by the fact that when specifically asked whether they would practice active voluntary euthanasia if it were legal, 40% of the doctors in the Victorian survey and 48% of the respondent doctors in the South Australian survey indicated that they would. These figures must be compared with the significantly smaller proportion of doctors who admitted to having already practiced active voluntary euthanasia: in both the Victorian and the South Australian survey, 29% of respondent doctors who had been asked by patient to actively assist him or her to die had helped at least one patient to do so.²⁶³ However, the survey results also reveal that many more doctors would be prepared to support active voluntary euthanasia in principle (62% Monash survey, 61% in the survey of South Australian doctors) and even endorse its legalisation (60% Monash survey, 56% in the survey of South Australian doctors), but would not themselves be willing to become involved in the practice - 41% of the respondent doctors in the Monash survey and 48% of the doctors in the South Australian survey said that they would not practice active voluntary euthanasia, even if it were legal.²⁶⁴

²⁵⁷ Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 626; Robertson and Tobin, 53.

²⁵⁸ Approximately 60% compared with approximately 75% amongst the general public.

²⁵⁹ Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 626.

²⁶⁰ *Ibid.* where it is noted that 51 of the 107 doctors who said that they had taken active steps signed their questionnaires.

²⁶¹ This and subsequent references to the survey of South Australian doctors are to the 1992 survey undertaken by the Medical Practitioners Concerned with Assisted Dying; see above, n. 256.

²⁶² See above, 264. The results of the Flinders Medical Centre survey also suggested that the present illegality of active voluntary euthanasia may be preventing a substantial proportion of doctors from engaging in the practice; Robertson and Tobin, 59.

²⁶³ It can be assumed that most of the doctors who have already practiced active voluntary euthanasia would probably be willing to do so again if the practice were made legal.

²⁶⁴ Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 625.

A very significant outcome of the survey was the fact that a majority of the doctors who responded to the questionnaire, (most of whom were members of the A.M.A.), thought that their professional association should take a similar stand to that which has been taken by the Royal Dutch Medical Association. As the authors of the survey have suggested, this result must raise serious questions about the current policies of the A.M.A. on the subject of active voluntary euthanasia.²⁶⁵ Following the release of the results of the Victorian survey of doctors' practices and attitudes, one of the authors of the survey, Professor Peter Singer, called on the A.M.A. to review its ban on active voluntary euthanasia.²⁶⁶ He argued that although active voluntary euthanasia would still be illegal even if the A.M.A. ethical rules were changed, A.M.A. pressure could influence a change in the law.²⁶⁷ This call for review was, however, promptly rejected by the A.M.A.. The federal President of the A.M.A., Dr Bryce Phillips is reported to have said that the association would continue to support the World Medical Association position on active euthanasia - that active euthanasia is an act of killing and as such was fundamentally against the basic oath of the medical profession. Further, he said that the survey, while interesting, did not lead him to believe that there was a widespread desire among members to change the A.M.A.'s ethical position on the matter, and that the profession and the community should view such a suggestion with great concern and caution.²⁶⁸ Similar comments were also made by the Executive Director of the A.M.A.,²⁶⁹ and the President of the Victorian branch.²⁷⁰

Although the issue of active voluntary euthanasia has, from time to time, been raised at council meetings, neither the A.M.A. nor other professional medical associations in Australia have conducted any surveys or polls of their members or doctors generally concerning attitudes to active voluntary euthanasia, and in view of the existing survey results, and the stir which those results created, they may well be reluctant to do so. The situation clearly poses a dilemma for the A.M.A.. Notwithstanding convincing evidence to suggest that members of the association support active voluntary euthanasia, the association is obviously reluctant to publicly advocate a position which is in conflict with the criminal law. Though the reaction from the association's leadership to the survey results is, in all the circumstances, perhaps understandable, to deny that these results present a case for review is to blatantly ignore the weight of the evidence. In the light of this evidence, the onus is now on the medical profession in general and the A.M.A. in particular, to review their official opposition to active voluntary euthanasia.²⁷¹ To date, the only branch of the A.M.A. which has undertaken a review of its position with regard to active voluntary euthanasia has been the South Australian

²⁶⁵ *Id.* 626.

²⁶⁶ *The Daily Telegraph* 21 June 1988.

²⁶⁷ *Ibid.*

²⁶⁸ Note, 'Intervention Still Constitutes Murder' (1988) *Med. Practice* 3.

²⁶⁹ *The Age* 20 June 1988, in which Mr Ron Hastings is reported to have said that the results of the survey should be 'viewed askance' because they contradicted his knowledge of doctors' views and the ethical basis of the medical profession.

²⁷⁰ *The Daily Telegraph* 21 June 1988 in which Dr Ken Sleeman is reported to have said that although the survey would stimulate useful public debate it was inadequate and did not provide a case for changing the A.M.A.'s ethical rules.

²⁷¹ See also the call for a review made by Dr Rodney Syme ('A Missing Voice in the Euthanasia Debate') *the Age* 21 March 1992.

Branch. In 1991 the Branch Council of the A.M.A. in South Australia established a working party on euthanasia. However, the efforts of the working party were for some time directed to the preparation of a submission to the South Australian Select Committee Inquiry into Death and Dying²⁷² and the working party is yet to release its report on the subject of euthanasia.

In sharp contrast to the position taken by most Australian medical organisations, the Doctors' Reform Society has publicly endorsed active voluntary euthanasia. Established in 1973, the Doctors' Reform Society is an organisation which aims to promote reform and improvement in Australian health services and changes in Australian society conducive to the health of the Australian people. It seeks to pursue these aims by promoting informed debate among doctors, by publication of the journal 'New Doctor,' and by participation in the democratic processes of our society.²⁷³ At its national conference in Brisbane in 1988, the society formally adopted a policy statement in which *inter alia*, it supported the legalisation of active voluntary euthanasia.²⁷⁴ The society has advocated the creation of a patients' bill of rights, which would include the right to be able to request a medically assisted death when suffering a fatal and distressing illness.²⁷⁵ The statement goes on to provide that patients' rights should be protected by legislation, particularly with regard to the 'right to die'.²⁷⁶ On the specifics of implementation of such a proposal, it is stated that legislation allowing both passive and active euthanasia should be based on the Netherlands criteria:

- only doctors may carry out euthanasia;
- individual doctors are free to refuse to carry out euthanasia;
- there must be an explicit request by the patient which leaves no room for doubt concerning the patient's desire to die;
- the patient's decision must be well-informed, free and enduring;
- there is no acceptable alternative (for the patient) to improve his/her condition;
- the doctor must exercise due care in making the decision and consult another independent medical practitioner.²⁷⁷

In view of its status as a reform society, it is perhaps not surprising that it should advocate the legalisation of active voluntary euthanasia alongside other reforms including introduction of a total ban on the promotion of smoking and alcohol, the development and implementation of a national nutritional policy, and a broadening of the medical curriculum.

Another noteworthy development has been the establishment in South Australia of a doctors organisation entitled Medical Practitioners Concerned with Assisted Dying. This organisation, working in consultation with the South Australian Voluntary Euthanasia Society, has put forward a

²⁷² Note, 'AMA's Recommendation to Inquiry into Death and Dying' (1991) *S.A. Med. Rev.* (Aug.) 22.

²⁷³ See the statement of aims and philosophy in the society's journal, *New Doctor*.

²⁷⁴ Note, 'Doctors' Reform Society Policy Statement' (1988) 49 *New Doctor* para. 3.1.12 and 3.3.

²⁷⁵ *Ibid.* para. 3.1.12. See also para. 3.1.11 recommending recognition of the right not to have life needlessly prolonged when suffering a fatal and distressing illness.

²⁷⁶ *Id.* 2. Other areas for which the society recommended legislative protection included health complaints, informed consent, confidentiality and access to records.

²⁷⁷ *Id.* 3.3.

proposed law for medical aid-in-dying along similar lines to the position prevailing in the Netherlands.²⁷⁸ Plans are underway for the formation of a similar group of doctors in Victoria.²⁷⁹

Apart from the survey results discussed above²⁸⁰ and information obtained from interviews with members of the medical profession which have confirmed the survey findings,²⁸¹ there are a number of other more general indicators of the attitudes of doctors in Australia with regard to active voluntary euthanasia. These include more extensive and open discussion of the subject in recent years both in the context of formal and informal meetings of professional medical associations²⁸² and at medical conferences.²⁸³ There has also been increasing coverage of the issue in Australian medical journals, including the prestigious *Medical Journal of Australia*. Numerous articles have been published on the subject which adopt a neutral and even-handed stance, and in the past few years, more and more doctors have been writing in defence of active voluntary euthanasia.²⁸⁴

There have also been other developments within the medical profession in Australia which have, in a more general way, impacted upon the voluntary euthanasia movement in this country. One such development has been the recognition of the importance of palliative care and the need to better promote this area of medicine. Although palliative care is, in many respects, a traditional part of medicine, it has, in recent times, acquired the status of a discipline in its own right. As interest in the area has grown, numerous palliative care programs have been established in Australia.²⁸⁵ There is, however, still widespread lack of information and understanding of palliative care in this country, not only within the community, but even amongst the medical profession.²⁸⁶ These shortcomings in palliative care and, in particular, lack of appropriate medical education in this area, are now increasingly being recognised.²⁸⁷ In an attempt to address some of these perceived deficiencies, efforts

²⁷⁸ Medical Practitioners Concerned with Assisted Dying, Media Release, 'South Australian Doctors Help Incurable Patients to Die' 28 July 1992.

²⁷⁹ Note, 'Voluntary Euthanasia Groups of Doctors and of Nurses Proposed' (1992) 76 *V.E.S.V. Report* 5.

²⁸⁰ See above, 264-268.

²⁸¹ In the course of interviews conducted by the writer with doctors involved in the care of elderly and terminal patients, there was clear support, from some doctors for a change in the law to allow for active assistance in certain carefully defined circumstances.

²⁸² On the basis of correspondence with the major medical associations in Australia it appears that the issue of active voluntary euthanasia has been raised and discussed at meetings from time to time.

²⁸³ For example, in 1984, the Annual Scientific Meeting of the Royal Australasian College of Physicians, where a number of papers were devoted to the subject of euthanasia; see J. Hickie, 'Euthanasia 1984' (1984) 141 *M.J.A.* 140; Note, 'Standing Room Only at Euthanasia Seminar' (1991) *Tastalk A.M.A. Newsletter* (Sept.) reporting on a very well attended seminar on euthanasia arranged by the Tasmanian Palliative Care Foundation held in Hobart, Tasmania.

²⁸⁴ See also Note, 'Voluntary Euthanasia - An Idea Whose Time Has Come' (1990) 70 *V.E.S.V. Report* 1-2. For recent examples, see Ellard, 'Euthanasia and the Death of Freud'; Syme, 'A Patient's Right to a Good Death'.

²⁸⁵ I. Maddocks, 'Changing Concepts in Palliative Care' (1990) 152 *M.J.A.* 535.

²⁸⁶ Parliament of Victoria Social Development Committee, Second and Final Report, *Inquiry into Options for Dying with Dignity* (1987) 221-222.

²⁸⁷ *Ibid.* See also J. Buchanan *et al.*, 'Medical Education in Palliative Care' (1990) 152 *M.J.A.* 27; Maddocks, 535; South Australian Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying, *Interim Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1991) Appendix E, Summary of Evidence, 2; and the recommendations made by the committee in the *Second Interim Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1992) 15-27.

are underway to clarify the role of the doctor in palliative care in Australia²⁸⁸ and to ensure that the subject of palliative care is incorporated within the curriculum for undergraduate medical students.²⁸⁹

Closely connected with developments in the area of palliative care has been the growth of the hospice movement in Australia. Considerable overlap exists between the concepts of 'palliative care' and 'hospice care':²⁹⁰ indeed, the terms are sometimes used interchangeably.²⁹¹ The modern hospice movement emerged in the 1960s and 70s by way of humanitarian response to concerns about the human costs of advancements in medical technology, and has, as its paramount aim, the improvement of the quality of life for the terminally ill. Dame Cicely Saunders, of St. Christopher's Hospice, London, is generally credited as being the founder of the modern hospice movement.²⁹² Although there had been some pioneering work in Australia by religious orders such as the Little Company of Mary, established as early as the beginning of this century, the main stimulus for the hospice movement in Australia came from the developments in the United Kingdom and other jurisdictions.²⁹³ The Melbourne City Mission Hospice Program, established in the late 1970s, was the first modern hospice program introduced in Australia based on the model of St. Christopher's Hospice in London, and since then, numerous hospice programs of various models have been established.²⁹⁴

These developments in palliative and hospice care in Australia are, indirectly at least, of significance for the voluntary euthanasia movement in that they reflect growing recognition within the medical profession of the needs of the dying. It must be noted, however, that many of those involved in the provision of palliative and hospice care are opposed to the legalisation of active voluntary euthanasia and they unequivocally reject any alliance with the voluntary euthanasia movement.²⁹⁵ Proponents of active voluntary euthanasia in Australia, on the other hand, whilst welcoming developments in palliative and hospice care, maintain that these developments do not obviate the need for active voluntary euthanasia. They argue that there is a genuine need for both improved terminal care as well as active voluntary euthanasia, and that the work and objectives of the hospice care movement and the voluntary euthanasia societies should accordingly be seen as complementing one another rather than being in competition.

Another relevant development within the medical profession which has contributed in the process of reform towards recognition of active voluntary euthanasia in Australia has been the increased emphasis

²⁸⁸ D. Allbrook, 'Doctors' Role in the Australian Hospice Movement' (1982) *M.J.A.* 502.

²⁸⁹ For developments in the State of Victoria, see Buchanan *et al.*

²⁹⁰ Maddocks, 535.

²⁹¹ For example, Department of Health, Tasmania, Discussion Paper 'Palliative Care Service Development Group' (1990) 6.

²⁹² See S. Du Boulay, *Cicely Saunders* (1984).

²⁹³ See Maddocks, and J. Cavanaugh and F. Gunz, 'Palliative Hospice Care in Australia' (1988) 2 *Palliative Med.* 51 for an outline of the beginnings of palliative care services in Australia.

²⁹⁴ Cavanaugh and Gunz; I. Renzenbrink, 'The Challenge of Hospice Care,' paper delivered at a hospice/palliative care conference 'Living Through Dying' Hobart, Nov. (1988).

²⁹⁵ For example, Dr Brian Pollard, who has for some years been in charge of a palliative care service at a large teaching hospital in Sydney. For an outline of his perspective, see his book, *Euthanasia*.

on the subject of medical ethics. Although at one time, doubt existed as to whether this represented a distinct field of study,²⁹⁶ the importance of the subject is now beyond dispute. In recent years, a number of research centres and institutions have been established in Australia which are involved in teaching and research in this field,²⁹⁷ as well as numerous institutional ethics committees vested with the responsibility of ethical decision-making.²⁹⁸ Recognition of the importance of medical ethics has also prompted reappraisal of medical school curricula with a view to including some teaching of medical ethics as part of the undergraduate program.²⁹⁹ This developing conception of medical ethics has contributed to the movement for voluntary euthanasia in Australia by stimulating debate on the issue within the medical profession, together with related matters such as informed consent, patient autonomy, self-determination and medical paternalism. Informed debate in this area is to be encouraged, and, in the longer term, can only assist in promoting understanding and acceptance of the concept of active voluntary euthanasia.

To a large extent, developments within the medical profession in Australia with regard to the issue of active voluntary euthanasia mirror developments which have occurred in other jurisdictions. Brief consideration will now be given to the main developments which have taken place in recent years in the United Kingdom and the United States.

United Kingdom

As was noted earlier,³⁰⁰ the origins of the modern voluntary euthanasia movement in the United Kingdom stem from the work of Dr Millard in the 1930s, and since that time, many British doctors have publicly expressed their support for the legalisation of active voluntary euthanasia.³⁰¹ However, the official position of the medical profession has been to consistently condemn any such proposal. There have, nevertheless, been a number of significant developments, prominent amongst which have been the inquiries initiated by the British Medical Association (B.M.A.) first in 1969, and more recently, in 1988, to examine the problem of euthanasia. Although the legalisation of active voluntary euthanasia was ultimately rejected by both of these inquiries, the fact that these inquiries were even undertaken is a matter of some significance, demonstrating a willingness on the part of the B.M.A. to undertake a review of its traditional opposition to active voluntary euthanasia. Apart from the review undertaken by the South Australian branch of the A.M.A., the B.M.A. is the only

²⁹⁶ Chambers, 23.

²⁹⁷ For example, the Monash Centre for Human Bioethics and the St. Vincent's Bioethics Centre, Melbourne.

²⁹⁸ P. McNeill, C. Berglund and I. Webster, 'Reviewing the Reviewers: A Survey of Institutional Ethics Committees in Australia' (1990) 152 *M.J.A.* 289.

²⁹⁹ For example, N. Hicks, 'Last Place in the Intensive Curriculum: Ethics for Health Service Students' in *Issues in Ethics* (1982) 1, 8.

³⁰⁰ See above, 243.

³⁰¹ Since the inception of the V.E.S. (U.K.) in 1935, doctors have been actively involved in the running of the society, with a number of well-known doctors holding senior positions in the society; e.g. Lord Moynihan, eminent surgeon, was the first President of the society and more recently, Dr Jonathon Miller, has held office as Vice-President.

professional medical association to undertake a review of this kind in the common law jurisdictions under consideration. That this occurred in the United Kingdom can best be understood in light of the repeated efforts by voluntary euthanasia proponents in that jurisdiction dating back to the mid 1930s to introduce legislation permitting active voluntary euthanasia.

Another significant development in the United Kingdom, which parallels developments within the Australian medical profession, has been the growing evidence from surveys that substantial support exists for the legalisation of active voluntary euthanasia amongst members of the medical profession. These survey results contradict the findings of the B.M.A. reports that the medical profession remains opposed to the legalisation of active voluntary euthanasia. Moreover, the B.M.A. purports to represent the majority of doctors in the United Kingdom.³⁰² However, on the basis of these survey results, there is strong evidence to suggest that the rejection of active voluntary euthanasia in the official reports of the B.M.A., most recently in 1988, is contrary to the views of the medical profession in the United Kingdom as a whole.

The B.M.A. policy, first declared in 1950, has been to unequivocally condemn active voluntary euthanasia.³⁰³ In 1969, the representative body of the B.M.A. passed a resolution confirming this position and instructing the B.M.A. council to give this view full publicity.³⁰⁴ Pursuant to this resolution, the Board of Science and Education of the B.M.A. appointed a panel of ten doctors, chaired by Dr Hugh Trowell, to consider the problem. However, the panel was effectively bound by the earlier resolution of the representative body in 1969 condemning active voluntary euthanasia, so its role was not really to examine the problem afresh, but simply to supply suitable arguments in support of the decision which had already been made.³⁰⁵ It was, in all the circumstances, not surprising that the report of the special panel,³⁰⁶ released in 1971, roundly condemned active voluntary euthanasia.³⁰⁷ The report contained most of the standard arguments which had previously been raised in the euthanasia debate. It was, for example, claimed that most people, even those suffering from cancer, die in peace and dignity, thereby implying that active voluntary euthanasia was unnecessary and that doctors saw no need for legislation. In response to suggestions that some doctors were already performing active voluntary euthanasia, the panel expressed the view that if this does occur, it is confined to the very few and cannot be condoned. In rejecting legislation permitting active voluntary euthanasia, much emphasis was placed on the perceived dangers of such legislation and the impossibility of providing adequate safeguards. The report concluded that:

³⁰² Approximately 80% of doctors in the United Kingdom belong to the B.M.A.

³⁰³ See Trowell, 19-20; B.M.A., *Handbook of Medical Ethics* (1984) 65 para. 10.33 which states that '...the profession condemns legalised active voluntary euthanasia.'

³⁰⁴ Trowell, 19-20; G. Williams, 'Euthanasia and the Physician' in M. Kohl, (ed.) *Beneficent Euthanasia* (1975) 145-146.

³⁰⁵ Williams, 'Euthanasia and the Physician,' 145-146; Voluntary Euthanasia Society, 'Doctors and Euthanasia: A Rejoinder to the British Medical Association's Report "The Problem of Euthanasia,"' (1971) (Extracted in Trowell, Appendix B, 161-171, hereafter referred to as the V.E.S. Rejoinder to the B.M.A.'s Report.)

³⁰⁶ British Medical Association, *The Problem of Euthanasia*: (1971) (Extracted in Trowell, Appendix A, 151-158).

³⁰⁷ *Ibid.* For commentary on the report, see Trowell, 21; Note, 'Against Euthanasia' (1971) *Lancet* (Jan-March) 220.

Euthanasia legislation would be a licence for the killing of human beings...Euthanasia cannot be accepted by the medical profession; in rejecting it doctors will be supported by the majority of laymen, who share the belief that the deliberate killing of a helpless person can never be condoned....Killing patients is no part of the work of doctors and nurses.³⁰⁸

The report met with sharp criticism from the Voluntary Euthanasia Society.³⁰⁹ The society accused the panel of having reached its conclusions even before it had commenced to sit, and claimed that in doing so, the panel had failed to adequately address fundamental issues, including the patient's right of self-determination.³¹⁰ The society also alleged that the panel had ignored relevant information from National Opinion Poll surveys of general practitioners conducted in 1964 and 1965. These surveys revealed that nearly half of the practitioners polled had been confronted with a request for active euthanasia (48.6%), many believed that if active voluntary euthanasia were made legal in certain circumstances, appropriate safeguards could be devised (44.3% answered yes, 43.5% answered no to this question) and further, more than one-third of the respondents (35.8%) said that they would be prepared to administer active voluntary euthanasia if it became legally permissible.³¹¹

For many years, the 1971 report of the special panel was taken to represent the position of the B.M.A., and it was not until 1986 that steps were taken for a review of the association's guidelines on euthanasia. At the 1986 annual representative meeting of the B.M.A., a resolution was passed urging the B.M.A. 'to reconsider its policy on euthanasia'. The B.M.A.'s council subsequently approved a recommendation from the association's central ethical committee providing for the establishment of a working party on euthanasia and setting out its terms of reference.³¹² The working party, chaired by Sir Henry Yellowlees, met during 1987/88. In May 1988, its report was considered at a meeting of the B.M.A.'s council at which the council agreed that the report should be published to restate the association's advice on euthanasia. It is interesting to see how history has virtually repeated itself with the emergence of this report, some 17 years after the initial report condemning euthanasia, which has also attracted criticism.

As with the earlier B.M.A. report, the 1988 report of the working party restates many of the well established arguments against active voluntary euthanasia.³¹³ The report³¹⁴ upholds the distinction

³⁰⁸ Trowell, 157-158.

³⁰⁹ V.E.S. Rejoinder to the B.M.A.'s Report.

³¹⁰ Trowell, 160, 162.

³¹¹ *Id.* 161, 167.

³¹² The terms of reference for the Working Party were: 'to examine: a) problems relating to euthanasia, terminal illness and suicide; b) U.K. law relating to suicide and homicide; c) guidance and instructions given by different religions, e.g. Protestant, Catholic, Jewish, Hindu, Buddhist; d) the present theoretical position in the U.K. as stated in the B.M.A. *Handbook of Medical Ethics*; and e) current practice and trends in euthanasia in other countries, for example the Netherlands'. (See the Foreword to the Report.)

³¹³ For example, that euthanasia is unnecessary (at 12); that its legalisation would be socially dangerous and would undermine the doctor/patient relationship (at 17-20, 59). For analysis of these arguments, see chapter V, 201-221.

³¹⁴ B.M.A., Working Party Report, *Euthanasia* (1988).

between active and passive euthanasia³¹⁵ and recommends that an active intervention to terminate another person's life should remain illegal. Whilst acknowledging the importance of patient autonomy and the right of patients to decline treatment, the working party was of the view that patients do not have the right to demand treatment which doctors cannot in good conscience provide. The working party stated that requests for active voluntary euthanasia are requests for doctors to act in ways that are at variance with all their training and inclinations and that the medical profession has a right to limit patient autonomy where the patient demands some treatment or action that runs counter to settled and informed medical opinion.³¹⁶ It was found that an active intervention by a doctor to terminate a patient's life falls within this category and patients should not be able to require their doctors to collaborate in their death.³¹⁷ In the words of the working party:

We do not, at present, see that any general policy condoning medical interventions to terminate life can be reconciled with the commitments of good medical practice. As a profession, we must stand by the commitments that lead us to preserve life and meet suffering creatively.³¹⁸

Evidence of public opinion polls indicating widespread agreement with the idea of active voluntary euthanasia was summarily dismissed, *inter alia*, on the grounds that the working party did not accept that 'tailoring what is morally right to the opinion of the majority is necessarily correct'.³¹⁹

The working party sought to bolster its views by invoking the distinction between intention and consequences, which it described as an important reference point in the moral assessment of any action.³²⁰ Thus, the distinction between active and passive euthanasia was justified on the basis that a decision to withdraw treatment, which has become a burden and is no longer of continuing benefit to a patient, has a different intent to one which involves ending the life of a person.³²¹ On the same grounds, the working party was prepared to accept drug treatment which may involve a risk to the person's life if the sole intention is to relieve illness, pain, distress or suffering.³²² However, the working party warned that any doctor, compelled by conscience to intervene to end a person's life, would have to be prepared to face the closest scrutiny of this action that the law might wish to make.³²³

The report concludes with a restatement of the central position of the working party:

The law should not be changed and the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well

³¹⁵ Note the Working Party's definitions of active and passive euthanasia; B.M.A. Working Party Report, *Euthanasia*, 3.

³¹⁶ *Id.* 18.

³¹⁷ *Id.* 67. (Emphasis in the original.).

³¹⁸ *Id.* 19-20.

³¹⁹ *Id.* 41-42.

³²⁰ *Id.* 24-26, 68.

³²¹ *Id.* 68.

³²² *Ibid.*

³²³ *Id.* 69.

being to social policy. It is instead, an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel.³²⁴

The report of the working party is undoubtedly of significance, ostensibly involving a thoroughgoing review of the B.M.A.'s guidance on euthanasia. This is to be contrasted with the report prepared by the special panel in 1971, since the panel was effectively bound by an earlier resolution of the representative body condemning euthanasia. The working party report therefore represents the first major review of the association's guidelines ever to be undertaken.

The report has, however, attracted considerable criticism from a variety of sources.³²⁵ It has been criticised on the grounds that it is a superficial document which fails to fairly present the arguments of the opponents, even to the point of misrepresenting the opponents' position.³²⁶ Furthermore, the report has been criticised for its conservatism and lack of originality.³²⁷ In particular, it has been attacked on the grounds that it perpetuates traditional, but arguably irrelevant, distinctions between active and passive euthanasia, and between intention and consequences. Critics claim that, as a result, the report is flawed by inconsistencies and fails to adequately deal with the complex problems in this area.³²⁸

A particularly disturbing criticism which has been levelled at the report is that it gives the impression of bias towards a predetermined outcome leaving the reader in some doubt as to whether there was a genuine attempt to critically review the B.M.A.'s guidance on euthanasia.³²⁹ Because the traditional opposition of the medical profession to active voluntary euthanasia is so deeply entrenched, it was all the more necessary for the inquiry to be conducted objectively and impartially. One of the specific complaints made by the Voluntary Euthanasia Society which illustrates its concern in this regard was that when it became necessary for one of the members of the working party (Dr Jonathon Miller, known for his pro-euthanasia views) to withdraw from the project, the chairman of the working party refused to accept a doctor sympathetic to, or at least open-minded about active voluntary euthanasia as a substitute.³³⁰

Aside from these criticisms, probably the most serious shortcoming of the report is its cursory treatment of opinion poll results gathered in the United Kingdom. Over the years, a number of

³²⁴ *Ibid.*

³²⁵ For example, J. Davies, 'Euthanasia' (1988) 297 *B.M.J.* 131; P. Nowell-Smith, 'Euthanasia and the Doctors - A Rejection of the B.M.A.'s Report' (1989) 15 *J. Med. Ethics* 124; R. Higgs, 'Not the Last Word on Euthanasia' (1988) 296 *B.M.J.* 1348; J. Beloff, 'Why the B.M.A. is Wrong' (1989) Jan. *V.E.S. of Scotland Newsletter* 1; L. Kennedy, *Euthanasia* (1990) 21-27; Note, 'Reports Encourage Respect for Dying Patients' Wishes' (1988) 38 *I.M.E.Bull.* 13.

³²⁶ For example, Nowell-Smith, 124-126; Higgs, 1348; Note, 'Reports Encourage Respect for Dying Patients' Wishes,' 17; Beloff, 1-3; Davies, 131.

³²⁷ Note, 'Reports Encourage Respect for Dying Patients' Wishes,' 19.

³²⁸ For example, Nowell-Smith, 124-128; Note, 'Reports Encourage Respect for Dying Patients' Wishes,' 19.

³²⁹ For example, Higgs, 1348; Nowell-Smith, 128; Kennedy, 21.

³³⁰ Minutes of the Annual General Meeting (1988) 35 *V.E.S. Newsletter* 2; Note, 'Letter from Jonathon Miller' (1988) 34 *V.E.S. Newsletter* 2; Note, 'Voluntary Euthanasia: Bridging the Credibility Gap' (1991) 41 *V.E.S. Newsletter* 6.

opinion polls have been commissioned by the Voluntary Euthanasia Society to ascertain the views of general practitioners and the public generally on the issue of active voluntary euthanasia.³³¹ Of particular relevance to this report was a telephone survey of some 300 British general practitioners, commissioned by the Voluntary Euthanasia Society and carried out by National Opinion Poll Market Research Ltd in 1987.³³² As part of that survey, general practitioners were asked:

Some people say that the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided they have previously requested such help in writing. Do you agree or disagree with this?

Thirty percent of respondent general practitioners said that they agreed with this statement, 59% said that they disagreed with it and 9% had mixed views. A further question was then put to the general practitioners to gauge whether they would consider performing active voluntary euthanasia if the law were changed:

At the moment euthanasia is illegal. Suppose the law is changed to permit voluntary euthanasia and there was a patient on your list, whose case you knew well, who suffered from an incurable physical illness that was intolerable to them. If that patient made a signed request that you end his/her life, would you consider doing so or not?

Thirty-five per cent of the general practitioners polled said that they would definitely consider euthanasia in these circumstances and 10% said that they might possibly do so. The remainder said that they would not consider euthanasia in these circumstances. Though not quite registering the same level of support revealed in the survey of doctors undertaken in Australia,³³³ these results nevertheless indicate considerable support within the medical profession in the United Kingdom for active voluntary euthanasia and consequently cast serious doubt on some of the assumptions made in the working party report.

To a large extent, the arguments raised in the report against active voluntary euthanasia were based on the need to uphold the traditions of the medical profession, with various references to active euthanasia running counter to doctors' intuition, counter to settled and informed medical opinion and the basic ethical commitments of medicine.³³⁴ Such comments clearly imply that a consensus exists within the profession on the issue of active voluntary euthanasia, indeed, the whole tenor of the report is to categorically assert that active voluntary euthanasia is condemned by the medical profession as a whole. Significantly, however, no attempt was made by the working party to provide evidence in support of these assertions, by, for example, conducting a survey of its members to actually gauge their views on the subject.

³³¹ See above, 231-233 for reference to public opinion polls conducted in the United Kingdom.

³³² National Opinion Poll Market Research. *Attitudes Towards Euthanasia Among Britain's G.P.s.* London. N.O.P. Market Research Ltd. (1987).

³³³ For description and analysis of the Australian surveys, see above, 264-266. See Kuhse and Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', 626 for possible explanations for the differences in levels of support for active voluntary euthanasia as between the doctors surveyed in Victoria and in Britain.

³³⁴ B.M.A. Working Party Report, *Euthanasia*, 19-20.

In presenting its case for reform, the Voluntary Euthanasia Society had submitted results of opinion polls to the working party as evidence of support for active voluntary euthanasia amongst both the general public and general practitioners in the United Kingdom. The treatment of this evidence in the report is unsatisfactory, to say the least. Not only is the crucial evidence from the survey of general practitioners completely omitted, but the position of the Voluntary Euthanasia Society is seriously misrepresented.³³⁵ The report states:

The Voluntary Euthanasia Society (V.E.S.) has attempted to strengthen the case for active termination of life by conducting public opinion polls which purport to show widespread agreement with the idea of voluntary active euthanasia.³³⁶

The language used here, in particular, the word 'purport' carries overtones that the results were somehow manipulated or fabricated and incorrectly suggests that the Voluntary Euthanasia Society had itself conducted the polls in question, when in fact the working party had been given documentation which clearly indicated that the polls had been conducted by National Opinion Poll Market Research Ltd.³³⁷ Further, the report sought to attack the form of questions used in the polls without fairly presenting the full picture.³³⁸ The report is also to be criticised for its bald claim that opinion poll evidence is in any event suspect. The working party stated that 'we do not accept that tailoring what is morally right to the opinion of the majority is necessarily correct'.³³⁹ This may well be true, but the report fails to acknowledge that this argument can work both ways: if doctors' views are not in accord with the general population, they cannot plead their own majority opinion as having any more weight than their arguments warrant.³⁴⁰ Instead, the report reflects double standards, with frequent reliance being made on arguments based on majority medical opinion.

Even more telling was the complete failure of the report to address the opinion poll evidence which indicates a substantial minority of doctors in the United Kingdom support active voluntary euthanasia and would consider practicing it if it were made legal. To suggest that there was a deliberate suppression of the evidence regarding polls of general practitioners is admittedly a serious charge, but in all the circumstances this conclusion appears unavoidable. Evidence had been made available to the working party regarding attitudes of British general practitioners on the subject of active voluntary euthanasia which would have been particularly relevant in light of the fact that the working party had made no attempt to gather its own evidence with regard to these matters. The complete omission of this material in the report can only be explained on the grounds that the working party deliberately avoided information which would cast serious doubt on the view expressed in the report that the medical profession universally condemns legalised active euthanasia.

³³⁵ See also Nowell-Smith; 125-126 and Davies, 131.

³³⁶ B.M.A. Working Party Report, *Euthanasia*, 41.

³³⁷ Nowell-Smith, 125-126; Davies, 131.

³³⁸ See the B.M.A. Working Party Report, *Euthanasia*, 41-42 and criticism by Nowell-Smith, 125-126.

³³⁹ B.M.A. Working Party Report, *Euthanasia*, 41-42.

³⁴⁰ Higgs, 1348.

Although the report has attracted considerable criticism, the process of inquiry undertaken by the B.M.A. has nevertheless been significant, indicating some preparedness on the part of the British medical profession to re-evaluate its stance with regard to active voluntary euthanasia. Although ultimately reiterating the medical profession's traditional opposition to active euthanasia, the report has undoubtedly made some contribution to the reform process by fostering debate on the issue within the medical profession and the community generally. However, in the light of the evidence regarding medical opinion on the subject, serious doubt must be cast on the underlying assumption in the report that active voluntary euthanasia is condemned by the medical profession as a body. This evidence, and its notable omission in the report, must clearly affect the credibility and validity of the report as a whole.

The reaction to the recent prosecution of Dr Cox is evidence of the changing attitude of the British medical profession to the issue of active voluntary euthanasia. As noted in an earlier chapter, Dr Cox was convicted of the attempted murder of one of his patients who had died following the administration of a lethal dose of potassium chloride.³⁴¹ His conviction, and the imposition of a 12 month suspended prison sentence came as a shock to many doctors who had tended to assume that a jury would not convict in these circumstances. The *Cox* case has, as a result, been cause for serious reflection within the medical profession regarding the state of the present law. In an editorial in the leading *British Medical Journal*, the editor, Richard Smith, writes that it is time for the British to think deeply about euthanasia.³⁴² Commenting on the reaction to the verdict and sentence, he notes that the law is in effect the codification of the will of the people, and when there is such tension between a legal verdict and the people's thinking then it is time to reconsider the law. He suggests that a Royal Commission for the British to examine this issue and goes on to foreshadow the need for legislation to bring the law in step with modern thinking and to clarify what is acceptable.³⁴³

Dr Cox's case has recently come before the General Medical Council's professional conduct committee which is the doctors' regulatory body. Cox pleaded guilty to the charge but told the committee that although he had expedited the death of his patient, it was in any case imminent. The committee, which has wide powers, *inter alia*, to strike a doctor off the medical register, reprimanded and admonished Dr Cox but gave permission for him to continue working as a hospital consultant.³⁴⁴ This is unquestionably a very lenient outcome and suggests that the committee sympathised with, if not condoned, the doctor's actions.

³⁴¹ See chapter IV, 126-127.

³⁴² R. Smith, 'Euthanasia: Time For a Royal Commission' (1992) 305 *B.M.J.* 728.

³⁴³ *Id.* 729. A similar call for review was made in the *Nursing Times*; see *Nursing Times* 30 Sept. 1992.

³⁴⁴ *The Mercury* 19 Nov. 1992.

As has been the case in the United Kingdom, many notable and respected doctors in the United States have given their support to the legalisation of active voluntary euthanasia and have contributed significantly to the voluntary euthanasia movement.³⁴⁵ However, the American Medical Association (the largest medical association in the United States³⁴⁶) and other professional medical associations, whilst endorsing passive euthanasia in some circumstances,³⁴⁷ have consistently rejected active voluntary euthanasia.³⁴⁸

Notwithstanding the official rejection of active voluntary euthanasia by the professional medical associations in the United States, there are clear indications of growing support within the medical profession generally for legalisation of active voluntary euthanasia, or 'physician aid-in dying,' as it is sometimes referred to. Some of the most reliable indicators of changing attitudes on this issue are the various opinion poll surveys which have been conducted over the years. These surveys provide fairly unequivocal evidence that a growing number of doctors are in favour of legalisation, and would be prepared to practice active voluntary euthanasia if it were made legal. In addition to these opinion poll surveys there have been a number of other developments in recent years paralleling developments in Australia and the United Kingdom, which reflect growing interest and support within the medical profession for active voluntary euthanasia. These developments strongly suggest that the traditional opposition of the American Medical Association and similar organisations to active voluntary euthanasia may no longer reflect the views of the majority of their members. Whilst no official inquiry has yet been undertaken by the professional medical associations in the United States to review the profession's traditional opposition to active voluntary euthanasia, there is some evidence of a possible softening of the official position of the American Medical Association.

Over the years, quite a number of surveys of doctors' attitudes to active voluntary euthanasia have been conducted in the United States.³⁴⁹ In the late 1980s a number of surveys were conducted of the medical profession in California in the light of a reform initiative being proposed in that State for the

³⁴⁵ For detailed historical coverage of the position in the United States see Russel, chapters 4-7; Humphry and Wickett, chapters 1-7.

³⁴⁶ In 1991 the American Medical Association membership was 286,477. (Written communication, research Association, Department of Membership Information Services, May 1992.)

³⁴⁷ See chapter IV, n. 2.

³⁴⁸ See chapter IV, 113.

³⁴⁹ One of the earliest reported surveys was that conducted by the Euthanasia Society of America in 1941 involving a questionnaire sent to all the doctors of New York State. Approximately 80% of the respondents, comprising some 4000 doctors (a response rate of about 16%), answered that they were in favour of the legalisation of active euthanasia for incurable adult sufferers who asked for it; see Russel, 89-90. A number of studies were also conducted in the late 1960s and early 1970s; see R. Williams, 'Our Role in the Generation, Modification and Termination of Life' (1969) 124 *Arch. Internal Med.* 215 (survey of the members of the Association of American Physicians and the Association of Professors of Medicine in which 15% of those questioned favoured 'positive' euthanasia i.e. active euthanasia); N. Brown *et al*, 'The Preservation of Life' (1970) 211 *J.A.M.A.* 76 (mailed questionnaires sent to the staff doctors at two hospitals in Seattle; 31% favoured changes permitting 'positive' euthanasia and 27% percent said that they would practice it, with a signed statement by the patient or family, if there was a more tolerant climate.)

legalisation of active voluntary euthanasia.³⁵⁰ In 1987,³⁵¹ a survey of Californian doctors was commissioned by the Hemlock Society to gauge doctors' attitudes and practices with regard to active voluntary euthanasia. The survey questions were identical to those used in the Monash survey of doctors conducted by Kuhse and Singer in Victoria,³⁵¹ thus permitting some useful comparisons to be drawn between the results obtained in the two jurisdictions.³⁵²

In response to a question regarding the practice of active voluntary euthanasia, nearly 23% of the respondents in the Californian survey indicated that they had taken active steps to bring about the death of a patient who had requested such action.³⁵³ This compares with a 29% affirmative response rate in the Monash survey. Of the Californian doctors who had rejected a patient's request to hasten death, 16.5% did so solely because the action was illegal, 23% gave this as the primary reason for rejecting the request, while 40% said that this was part of the reason.³⁵⁴ Twenty percent said that the illegality of the action was not at all the reason for rejecting the request.³⁵⁵ In the results for the Monash survey: 5% of respondents gave this as their sole reason, 15% as the primary reason, 45% as part of the reason and 35% indicated that it was not a reason at all.

The Californian survey also sought to ascertain doctors' attitudes to taking active steps to bring about a patient's death at the patient's request. When asked if it was sometimes right to agree to hasten a patient's death, of the 600 doctors who responded to the poll, 62.5% said it was sometimes right to do so, while 37.5% disagreed.³⁵⁶ This is comparable with the results for the Monash survey; 62% answered yes while 34% answered no.

Having been provided with a description of the condition under which doctors in the Netherlands may end the life of a patient without attracting criminal prosecution, respondents were asked whether it would be a good thing if a similar situation existed in California. Sixty-seven per cent of the respondents agreed that it would be a good thing.³⁵⁷ This is significantly higher than the response to the same question for the Monash survey which was 62%. When asked about the appropriate role of their professional medical association with regard to this matter, 58% of the Californian doctors felt that their professional medical association should take a similar stand to that taken by the Royal Dutch Medical Association.³⁵⁸ Here again, the affirmative response was higher than amongst the Victorian doctors in the Monash survey of whom 52% felt that their professional medical association should take a similar stand to that of the Royal Dutch Medical Association. The Californian doctors

³⁵⁰ For discussion of these developments, see chapter VII, 339-341.

³⁵¹ See above, 264-266 and chapter IV, 118.

³⁵² Because of the similarity in survey questions as well as the proximity in time between these two surveys, attention will be focussed on a comparison of these results and reference will only indirectly be made to the more recent survey of South Australian doctors.

³⁵³ Note, 'Most California Doctors Favour New Euthanasia Law' (1988) 31 *Hemlock Q.* 1-2.

³⁵⁴ *Id.* 2.

³⁵⁵ *Ibid.*

³⁵⁶ *Id.* 1.

³⁵⁷ *Id.* 2.

³⁵⁸ *Ibid.*

were also asked whether the law should be changed to permit active voluntary euthanasia. More than two-thirds (68.7%) believed that the law should be changed,³⁵⁹ as compared with 60% in the Monash survey. Over one half (51% of the respondents) said that they would practice active voluntary euthanasia if it were legal,³⁶⁰ significantly more than the 41% of respondents in the Monash survey who indicated that they would be prepared to do so.

Whilst there are clear parallels to be drawn between the results obtained from the surveys conducted in California and Victoria, there are also some interesting differences to be noted. For example, in the Monash survey, significantly more doctors indicated that they had taken active steps to end a patient's life at the request of the patient (29% as compared to 23% in the Hemlock survey). Further, for those doctors who said that they had rejected a patient's request for active euthanasia, it appears that the present illegality of the practice was generally a more relevant factor in the minds of the doctors in the Californian survey than it was for the Victorian doctors.³⁶¹ One possible explanation for these differences is that the United States is a more litigious society which may generally discourage doctors in that jurisdiction to act in contravention of the law. Doctors in California may be particularly wary, following the case of *Barber v Superior Court*³⁶² in which two Californian doctors were charged with murder for disconnecting mechanical ventilation and intravenous lines from a severely brain-damaged comatose patient. Although the charges were ultimately dismissed, the case did highlight the potential criminal liability of doctors for passive euthanasia let alone for active interventions intended to end the life of a patient.

It is also interesting to note that although a very similar proportion of doctors in California and Victoria were of the view that it was sometimes right for a doctor to take active steps to hasten the death of a patient at the patient's request; (62.5% in the Hemlock survey compared with 62% in the Monash Survey), the doctors sampled in the Californian survey appear to be more in favour of change in this area. A consistently higher level of approval was recorded amongst the Californian doctors sampled in the Hemlock survey compared with Victorian doctors in response to questions with regard to: adopting the situation in the Netherlands - 67% (Monash survey 62%); their professional medical associations changing their stance - 58% (Monash survey 52%); a change of law to permit active voluntary euthanasia - 68.7% (Monash survey 60%); and whether they would be willing to practice active voluntary euthanasia if it were made legal - 51% (Monash survey 41%). These differences can perhaps be explained by the fact that doctors in the United States, and particularly in California, have

³⁵⁹ *Ibid.*

³⁶⁰ *Ibid.* See also the results of a study co-ordinated by the Center for Health Ethics and Policy Graduate School of Public Affairs, University of Colorado at Denver, *Withholding and Withdrawing Life-Sustaining Treatment* (1988). This survey involved a questionnaire sent to all doctors in Colorado, of which a total of 2,218 responded. Though dealing primarily with passive euthanasia, the survey revealed that 60% of doctors responding to the survey had attended patients for whom they believed active voluntary euthanasia would be justifiable if it were legal, and of those who had encountered such patients, 58.9% indicated that they would have personally been willing to administer a lethal drug if such measures were allowed by law. See the report, 15-16.

³⁶¹ Responses for the Hemlock and Monash surveys were as follows; 16.5% sole reason (Monash survey 5%); 23% primary reason (Monash survey 15%); 40% part of the reason (Monash survey 45%); 20% not at all the reason (Monash survey 35%).

³⁶² 195 Cal. Rptr. 484 (1983). For discussion, see chapter II, 62-63, 74.

had greater exposure to the problem of euthanasia and the possibility of reform in this area than have their Victorian counterparts. One only has to have regard to the enactment of 'living will' legislation in many American states, commencing with the Californian *Natural Death Act* in 1976, various landmark 'right to die' cases,³⁶³ and the ballot initiative to introduce legislation in California to permit active voluntary euthanasia, which was well underway at the time this survey was conducted,³⁶⁴ to understand why the doctors in the Californian survey were perhaps better informed on the subject and more willing to embrace change in this area.

Also in 1988, but some months after the release of the results of the Hemlock survey in California, the findings were published of a survey of doctors undertaken by the San Francisco Medical Society. The aim of this survey was to gauge the attitudes to active voluntary euthanasia of members of the San Francisco Medical Society in the light of reform initiatives being proposed in the State of California for the legalisation of active voluntary physician-assisted euthanasia.³⁶⁵ The survey covered some 1,743 San Francisco doctors, 676 of which responded (a total response rate of 38.8%). The results obtained in this survey are generally consistent with the earlier Hemlock survey and surveys undertaken in other jurisdictions, including Australia. The overwhelming majority of the doctors surveyed supported the view that patients should have the option of requesting active euthanasia when faced with incurable terminal illness: 70% in favour, with only 23% against.³⁶⁶ Another of the questions was directed at ascertaining members' views as to the doctors' role with regard to active euthanasia. Respondents were asked: 'If you do feel that legalisation of active euthanasia would be appropriate do you think that physicians should be the ones to carry out such requests?' More than half (54%) were of the view that if legal, active voluntary euthanasia should be carried out by physicians, while 26% disagreed.³⁶⁷ There appears, however, to have been considerable uncertainty with regard to this issue, with 11% unsure and 9% giving no answer to this question.³⁶⁸ On the question of preparedness to perform active voluntary euthanasia if it were made legal, 45% of the respondents indicated that they would, 35% said no.³⁶⁹ Once again, there was a relatively high rate of respondents undecided on this issue - 18% were unsure and 2% gave no answer.³⁷⁰

The survey conducted by the San Francisco Medical Society is significant. It represents the first survey of its kind undertaken by a professional medical association in any of the jurisdictions under consideration. Not only was an anonymous opinion survey of members undertaken, but the results of the survey were made public, even though one suspects that the Board of the San Francisco Medical Society may have been a little surprised, not to say disappointed, by the results obtained. This course

³⁶³ For example, *Bartling v Superior Court* 163 Cal. App. 3d 186 (1984) and *Bouvia v Superior Court* 225 Cal. Rptr. 297 (1986) See chapter II, 54-55.

³⁶⁴ For discussion, see chapter VII, 339-341.

³⁶⁵ S. Heilig, 'The S.F.M.S. Euthanasia Survey: Results and Analyses' (1988) *San Francisco Med.* (May) 24-6, 34.

³⁶⁶ *Id.* 24. Seven percent of respondents were unsure and 1% did not answer this question.

³⁶⁷ *Ibid.*

³⁶⁸ *Ibid.*

³⁶⁹ *Id.* 25.

³⁷⁰ *Ibid.*

of events can only be seen as evidence of a growing willingness within the medical profession to obtain an informed view on the subject and possibly re-evaluate its traditional opposition to the legalisation of active voluntary euthanasia.³⁷¹

It is interesting to compare the results from these recent surveys with the findings of earlier surveys conducted in the United States. On the basis of a number of studies conducted in the United States in the late 1960s and early 1970s, between approximately 10%-30% of the doctors surveyed were in favour of active euthanasia.³⁷² Against this background, the more recent surveys, indicating quite significant support for active voluntary euthanasia, are of particular relevance. Whilst caution must be exercised in attempting to compare the results of these different surveys, the more recent results appear to reflect growing support amongst the medical profession for active voluntary euthanasia. This development is consistent with the increase in support for active voluntary euthanasia reflected in public opinion polls in the United States.

Whilst the survey evidence is probably the clearest indication of attitudes to active voluntary euthanasia amongst doctors in the United States, there have been a number of other noteworthy developments which reflect growing acceptance within the medical profession of active voluntary euthanasia. A striking development which clearly signals change in this area is the increased level of informed debate on the subject of active voluntary euthanasia. It is a subject which is now openly being discussed amongst the medical profession and frequently features in the pages of the medical journals. More and more doctors, many of whom are well-known and respected, have publicly declared their willingness to re-examine the appropriateness of the current prohibitions on active voluntary euthanasia and assisted suicide.³⁷³

Illustrative of this trend has been the emerging consensus amongst a group of eminent doctors regarding care of the dying. This came about through the initiative of the Society for the Right to Die (now called Choice in Dying³⁷⁴) which had sponsored a number of conferences for a select group of doctors in the United States from diverse professional and institutional backgrounds, with the object of establishing guidelines in the care of dying patients.³⁷⁵ The deliberations and conclusions of the panel of doctors have subsequently been published in a series of special articles in the *New England*

³⁷¹ Prior to the survey, the San Francisco Medical Society did not have an official position on the subject of active voluntary euthanasia and on the basis of the survey results, the society decided not to take any such position, deferring to the individual and personal convictions of each member physician. (Written communication with the Director of Public Health and Education, San Francisco Medical Society, May 1992).

³⁷² See above, n. 349.

³⁷³ See, for example, M. Angell, 'Euthanasia' (1988) 319 *New Eng.J.Med.* 1348; S. Wanzer, 'Maintaining Control in Terminal Illness: Assisted Suicide and Euthanasia' (1990) 6 *Humane Med.* 186; C. Cassel and D. Meier, 'Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide' (1990) 323 *New Eng.J.Med.* 750; T. Quill, C. Cassel and D. Meier, 'Proposed Clinical Criteria for Physician-Assisted Suicide' (1992) 327 *New Eng.J.Med.* 1380; H. Brody, 'Assisted Death - A Compassionate Response to Medical Failure' (1992) 327 *New Eng.J.Med.* 1384.

³⁷⁴ See above, 250.

³⁷⁵ See above, 249-250.

*Journal of Medicine*³⁷⁶ and have attracted widespread publicity as a result of the eminence of the doctors involved as well as of the journal in which their views were published. At the second of these conferences, a group of twelve doctors considered the doctors' response to the dying patient who is rational and desires suicide or euthanasia. In the publication which followed tacit approval was given to physician-assisted suicide, with ten of the twelve doctors supporting the view that it is not immoral for a doctor to assist in the rational suicide of a terminally ill patient.³⁷⁷ And whilst active voluntary euthanasia was not openly advocated, the matter was dealt with in a sympathetic and even-handed manner, with the group refraining from outright condemnation of the practice.³⁷⁸ Although euthanasia opponents have sought to undermine the relevance of these conferences, and the resulting publications,³⁷⁹ these developments are of obvious significance. Not only have they attracted widespread publicity, but they have undoubtedly been influential in promoting understanding and acceptance within the medical profession of physician-assisted suicide and even active voluntary euthanasia.

Another noteworthy development was the publication of an article in the prestigious *American Medical Association Journal*, in which a doctor admitted to having taken active steps to hasten the death of a patient dying of cancer. The article, entitled 'It's Over Debbie',³⁸⁰ which appeared in the January 8 (1988) issue of the journal, briefly recounted the experience of a resident doctor who was called up in the middle of the night to attend to Debbie, a twenty year old female patient, dying of ovarian cancer. Her only words to the doctor were 'let's get this over with' to which the doctor responded by administering 20 m.g. of morphine intravenously. The doctor recollected how Debbie's breathing slowed, became irregular, and then ceased within a few minutes. The article, and its anonymous presentation in the journal, without editorial comment, stimulated substantial reaction from the medical professional, as well as the public, the media and legal authorities. The weight of opinion was against the resident's actions, with criticism even extending to the editors of the journal for publishing the article.³⁸¹ In a subsequent editorial, the editor, George Lundberg, defending his decision to publish the manuscript, stated that the article proceeded through the normal peer review process, and after some editorial debate, the decision was taken to publish the article in order to provoke responsible debate within the medical profession and the public about active voluntary euthanasia in the United States.³⁸² According to Lundberg, by publishing 'It's Over Debbie', the

³⁷⁶ S. Wanzer *et al*, 'The Physician's Responsibility to the Hopelessly Ill Patient' (1984) 310 *New Eng.J.Med.* 955; S. Wanzer *et al*, 'The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look' (1989) 320 *New Eng.J.Med.* 844.

³⁷⁷ *Id.* 847-848.

³⁷⁸ *Id.* 848-849.

³⁷⁹ For example, alleging bias in the selection of doctors in the group, and the fact that they were sponsored by the Right to Die Society which is a pro-euthanasia organisation.

³⁸⁰ (1988) 259 *J.A.M.A.* 272.

³⁸¹ See the letters to the editor arising from this publication; (1988) Vol. 259 No. 1. *J.A.M.A.* 272; (1988) Vol. 259 No. 2 *J.A.M.A.* 2094-2098. For coverage of this development, as well as a number of other developments contributing to the changing climate for reform in the United States, see N. Newman, 'Euthanasia: Orchestrating "The Last Syllable of....Time"' (1991) 53 *U.Pitt.L.Rev.* 153, 153-164.

³⁸² Note, "'It's Over, Debbie" and the Euthanasia Debate' (1988) 259 *J.A.M.A.* 2142.

Journal demonstrated its belief that the ethics of euthanasia must be debated anew.³⁸³ Although the publication of this article and the actions of the resident described therein have attracted much criticism both from within and outside the medical profession, even from proponents of euthanasia,³⁸⁴ it nevertheless marks a significant development within the medical profession in the United States. The fact that the item was published in the prestigious journal of the American Medical Association and the subsequent defence of that decision by the editor, clearly demonstrate an open-minded attitude to the issue active voluntary euthanasia and represents acknowledgment of the need to openly debate the issue. Whatever else this publication may have achieved, it certainly succeeded in its aim of promoting debate within the medical profession and the public about active voluntary euthanasia in the United States.

Debate on the subject of active voluntary euthanasia has also been stimulated as a result of a number of widely publicised cases of doctor-assisted suicide. The first of these cases involved Dr Jack Kevorkian and his so called 'suicide machine' which he has used to assist the suicide of a number of patients.³⁸⁵ Following the first incident, involving a patient who was suffering from Alzheimer's disease, Dr Kevorkian was charged with murder.³⁸⁶ This charge was subsequently dismissed on the grounds that there was no proof that he had carried out and planned the patient's death.³⁸⁷ From the outset, Dr Kevorkian has been very public in his advocacy of physician-assisted suicide, and has succeeded in attracting much publicity to the voluntary euthanasia cause. The reaction to Dr Kevorkian's conduct from the medical profession in the United States has been somewhat mixed: amongst some vocal opposition,³⁸⁸ he also received considerable support.³⁸⁹ Dr Kevorkian has since assisted a number of other patients suffering severe illnesses to commit suicide by providing suicide devices.³⁹⁰ Two further murder charges have been brought against Dr Kevorkian but these charges were dismissed on the grounds that he had not actually activated the devices which had caused the deaths so as to constitute homicide as distinct from assisted suicide which is not, at present, an offence in the State of Michigan.³⁹¹ Dr Kevorkian still faces possible murder charges in respect of a number of further deaths which were brought about with the assistance of his suicide devices.³⁹²

³⁸³ G. Lundberg, 'Debate Over the Ethics of Euthanasia' (1988) 259 *J.A.M.A.* 2143.

³⁸⁴ It has, for example, been argued that the actions of the doctor in this case were completely inappropriate because he knew virtually nothing of the patient's condition or circumstances and had acted impulsively on the basis of an ambiguous request.

³⁸⁵ See chapter IV, n. 78.

³⁸⁶ Assisting suicide is not an offence in the State of Michigan.

³⁸⁷ *People v Kevorkian* (unreported) *N.Y. Times* 14 Dec. 1990. For discussion, see Newman, 161-164.

³⁸⁸ See, for example, R. Weir, 'The Morality of Physician-Assisted Suicide' (1992) 20 *Law, Med. & Health Care* 116, 119-120.

³⁸⁹ The *Mercury* 12 Jan. 1991 which reports that the New York weekly *Medical Tribune* asked doctors to comment upon the actions of Dr Kevorkian: of the 250 that did so, 45% expressed approval of what Kevorkian had done. Further, in some of the letters received by the *Medical Tribune* doctors indicated that they had personally been involved in such activities. Another survey of doctors in the wake of the Kevorkian case was done by *American Press* in July 1990 in which an opinion poll was sent to 100 doctors: 30% of the doctors polled said that the actions of Dr Kevorkian in assisting in the suicide of a patient should be a legal act; Note, 'Polls, Polls and More Polls' (1990) 17 *World Right-to-Die Newsletter* 1.

³⁹⁰ The *Australian* 23 July 1992.

³⁹¹ *Ibid.*

³⁹² The *Australian* 23 July 1992; the *Mercury* 29 September 1992.

However, in view of the outcome of the preceding cases, it is unlikely that a conviction for murder would succeed. These cases, and the controversy surrounding Dr Kevorkian and his suicide devices, have certainly prompted debate within the medical profession regarding physician-assisted suicide and active voluntary euthanasia.

Another case of physician-assisted suicide which, in comparison with the incidents involving Dr Kevorkian, have attracted overwhelmingly favourable publicity was that involving Dr Timothy Quill. As noted in an earlier chapter, this case came to light as a result of an admission by Dr Quill, published in the *New England Journal of Medicine*.³⁹³ Dr Quill escaped liability on charges of assisting suicide as a result of the grand jury's refusal to indict. He later explained that his purpose behind publishing the account was to provoke greater public discussion of the treatment of terminally ill patients.³⁹⁴ His confession was welcomed by many doctors and ethicists as helping to remove taboos preventing doctors from discussing how they have helped their patients to die, and paving the way for a reassessment of the doctors' role.³⁹⁵

Significantly, there has recently been some indication of a willingness to possibly review the American Medical Association's official opposition to active voluntary euthanasia and physician-assisted suicide in the future. In a recent report, the American Medical Association's Council on Ethical and Judicial Affairs noted the increasing support for the proposition that physicians should be allowed to deliberately end a patient's life upon the patient's request.³⁹⁶ Whilst reiterating its position that physicians must not perform active voluntary euthanasia or participate in assisted suicide, the council recommended that a more careful examination of the issue is necessary.³⁹⁷ In particular, it observed that there is currently little data in the United States regarding the number of requests for active euthanasia or assisted suicide, the concerns behind the requests, the types and degree of intolerable and unrelievable suffering, or the number of requests that have been granted by health care providers.³⁹⁸ The council suggested that before active voluntary euthanasia can be considered a legitimate medical treatment in the United States, the needs behind the demand for physician provided euthanasia must be examined more thoroughly and addressed more effectively.³⁹⁹ The report concluded with a recommendation that the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone active voluntary euthanasia or physician-assisted suicide at this time.⁴⁰⁰ This report is significant in so far that it demonstrates the preparedness of the American Medical Association to further investigate the issue and possibly re-

³⁹³ T. Quill, 'Death and Dignity: A Case of Individualised Decision Making' (1991) 324 *New Eng.J.Med.* 691. See further, chapter IV, 120-125.

³⁹⁴ *New York Times* 27 July 1991.

³⁹⁵ For an illustration of the favourable reaction to the actions of Dr Quill, see N. Jecker, 'Giving Death a Hand: When the Dying and the Doctor Stand in a Special Relationship' (1991) 39 *J.Am. Geriatrics Society* 831.

³⁹⁶ American Medical Association, Council on Ethical and Judicial Affairs, *Decisions Near the End of Life* (1991) 245.

³⁹⁷ *Id.* 254.

³⁹⁸ *Id.* 251.

³⁹⁹ *Ibid.*

⁴⁰⁰ *Id.* 254.

evaluate its stance with regard to active voluntary euthanasia⁴⁰¹ and physician-assisted suicide at some later stage.

International Developments: The Appleton International Conference

Another significant development which has given recognition and qualified support to active voluntary euthanasia has been the Appleton International Conference. This development began in 1987 with an international working conference for practising clinicians regarding decisions to withhold or withdraw treatment.⁴⁰¹ Participants were drawn internationally from nearly a dozen countries and their deliberations led to the preparation of model guidelines with regard to forgoing treatment.⁴⁰² A further conference was held in 1991 to continue the development of internationally recognised guidelines with regard to forgoing life-prolonging medical treatment. At this conference consideration was, *inter alia*, given to requests for intervention intended to terminate life (active voluntary euthanasia). Although there was by no means unanimity on the issue, the following guidelines were suggested concerning requests for active euthanasia:

Patients having decision-making capacity who are severely and irremediably suffering from an incurable disease sometimes ask for assistance in dying. Such requests for active termination of life by a medical act which directly and intentionally causes death may be morally justifiable and should be given serious consideration. Doctors have an obligation to try to provide treatment and care that will result in a peaceful, dignified, and humane death with minimal suffering. There is a particular obligation upon the doctor confronted with a request for euthanasia or other assistance in dying to undertake a scrupulously careful enquiry into the circumstances of the request to see if alternative courses of action might be helpful in removing or alleviating the cause or causes that led to the request....

It is recognised that participation in doctor-assisted dying for those patients who persist in their wish to die in spite of all measures to reduce their suffering will reflect different cultural and societal norms in individual countries. Whether statutory legalisation of the international termination of life by doctors is desirable is the subject of continuing international debate.⁴⁰³

These carefully worded guidelines which gain international exposure are clearly intended to convey a degree of acceptance for active voluntary euthanasia. In so doing, they reflect the enormous changes that have occurred with regard to this subject, and in their own right, marking a significant milestone in the history of active voluntary euthanasia.

⁴⁰¹ J. Stanley, 'The Appleton International Conference: Developing Guidelines for Decisions to Forgo Life-Prolonging Medical Treatment' (1992) 18 *J. Med. Ethics* 3.

⁴⁰² These guidelines were published as 'The Appleton Consensus: Suggested International Guidelines for Decisions to Forgo Medical Treatment' in the *Journal of the Danish Medical Association* (1989).

⁴⁰³ Stanley, 6-7. Note the dissent to this guideline by 5 of the 24 participants.

From the foregoing review of developments within the medical profession in Australia, the United Kingdom and the United States with regard to the issue of active voluntary euthanasia, it is readily apparent that despite the official opposition of professional medical organisations, there is growing evidence of a changed outlook on the subject on the part of many doctors. It is more difficult to state with any certainty the reasons behind this change. A number of tentative suggestions can, however, be made which reinforce the important interrelationship between the changing attitude of the medical profession on the issue and changes in public opinion generally. Amongst possible reasons behind this clear shift in medical opinion is the increasingly open attitude in the community to death and dying. Although active voluntary euthanasia remains a crime, much of the taboo formerly surrounding the subject has disappeared and doctors are, therefore, increasingly willing to present their views on the subject. Doctors, as members of the community, can be taken to reflect, at least to some extent, the attitudes of the wider population which are unequivocally moving towards acceptance of active voluntary euthanasia. Moreover, as the evidence of public support for active voluntary euthanasia mounts, more and more doctors would be likely to acknowledge this development and respond to it, regardless of what their own personal views on the subject may be. This is particularly the case in view of the declining influence of medical paternalism and the growing recognition of the importance of patient autonomy and self-determination.

In the light of the overwhelming evidence of growing acceptance within the medical profession for active voluntary euthanasia, there is a strong case to suggest that if the professional medical associations are to remain relevant and representative of the views of their members, they must urgently re-examine their traditional opposition to the practice. Moreover, if such a review is to be effective and responsive to the needs of the medical profession as a whole, it is essential that a genuine effort is made to gauge the views of members of the profession. Indeed, as suggested earlier,⁴⁰⁴ it was primarily for this reason that the recent review undertaken by the B.M.A., whilst undoubtedly a development of major significance, ultimately failed to address the real issues in this area.

It has also been shown that apart from survey evidence of doctors' attitudes to active voluntary euthanasia, in all the jurisdictions under consideration there have been quite a number of other more general developments within the medical profession which have contributed to the process of reform. Widespread acceptance of passive euthanasia, changing attitudes to death and dying, the development of hospice and palliative care, and increased debate within the medical profession and the community generally on the subject of assisted dying are just some of the developments which have contributed to a growing understanding and acceptance of active voluntary euthanasia. The extent of this change, also from an international perspective, is evident from the deliberations of the Appleton International

⁴⁰⁴ For criticism of the report, see above, 276-278.

Conference which has led to the development of guidelines⁴⁰⁵ for medical practitioners concerning requests for active euthanasia.

Conclusion

The object of this chapter has been to outline the key features in the changing climate for reform of the law with regard to active voluntary euthanasia. Evidence from opinion poll results has shown that a large majority in Australia and the other common law jurisdictions under consideration support the legalisation of active voluntary euthanasia. The degree of community support is reflected in the expansion of the voluntary euthanasia movement, with the establishment and growth of voluntary euthanasia societies in all jurisdictions. Intermeshed with these developments, there has been a significant shift of opinion from within the medical profession towards acceptance of active voluntary euthanasia, although the implications of this shift are yet to be fully recognised by the official medical organisations. The analysis in this chapter evidences a clear trend towards greater acceptance of active voluntary euthanasia. In some jurisdictions, this development dates back a number of decades,⁴⁰⁵ whilst in others it is of relatively more recent origin. However, in all jurisdictions, there are indications that the trend has been gathering momentum in recent years, with ever increasing demands for changes to the present law. In the chapter which follows, consideration will be given to the measures which have to date resulted from this changing climate for reform.

⁴⁰⁵ See above, 243-244 and 247-248 for discussion of the history of the voluntary euthanasia movement in the United Kingdom and the United States

CHAPTER VII

REFORM DEVELOPMENTS IN AUSTRALIA AND OTHER COMMON LAW JURISDICTIONS

Introduction

The foregoing chapter has concentrated on the changing climate for reform within the medical profession and the community generally on the issue of active voluntary euthanasia, documenting the growing evidence of acceptance of the practice and support for its legalisation. Specific attention will now be given to the governmental response to these changes in the form of law reform commission and parliamentary inquiries. Consideration will also be given to legislative efforts, primarily initiated by the voluntary euthanasia societies, to introduce laws permitting active voluntary euthanasia. Although to date, these legislative efforts have been unsuccessful, there has been considerable reform activity in this area, particularly in the United Kingdom and the United States.

Australia

There have been a number of inquiries conducted in Australia in recent years which have touched on the issue of legalisation of active voluntary euthanasia, but the majority of these inquiries have not directly dealt with this issue. The relevant Australian inquiries have essentially taken two forms - either comprising part of a broader revision of the criminal law in the course of which some attention has been given to whether there is a need to change the law with regard to mercy killing,¹ or inquiries directed at the issue of patients' rights with regard to medical treatment, dealing with what is essentially passive euthanasia.

Criminal Law Inquiries

Whilst there have been a number of criminal law inquiries in Australian jurisdictions which have indirectly touched on the issue of active voluntary euthanasia, their focus has generally been mercy killings in the family context. As a result, these inquiries have been of limited relevance to the issue

¹ See the Introduction to this thesis, 4 for a definition of 'mercy killing' where it is explained that this term is usually used in the context of compassionate killings involving family or friends as distinct from medically administered active voluntary euthanasia.

of active voluntary euthanasia as understood for the purposes of this thesis; i.e. active voluntary euthanasia performed by doctors in the medical context.

In 1974, the Law Reform Commission of Victoria, as part of its reference with respect to the law of murder, examined the issue of mercy killing.² In particular, consideration was given to whether mercy killing, in the sense of 'an intentional killing, the motive of which is to spare the victim a continuance of severe suffering', should be removed from the definition of murder and reduced to the lesser offence of manslaughter. This proposal was rejected, and it was recommended that mercy killing should continue to be classed as murder.³ The Victorian Law Reform Commissioner was of the view that it would be unwise to change the law in this area because it would be likely to increase the number of people who inappropriately take upon themselves the responsibility of killing. Furthermore, it was pointed out that in many instances, the motive for the killing would be to relieve the killer from a burden and that it was thought undesirable to place temptation in the way of persons who carry such burdens to kill for their own relief and then to seek to evade full responsibility by asserting that their motive was to relieve suffering. The commissioner also made reference to the evidentiary difficulties involved in such cases, particularly in establishing the motive of the offender, in circumstances where the killer would usually be the only person able to give an account of what had occurred. It is clear from the nature of these objections that attention was primarily directed at mercy killings occurring in the family context: objections based for example, upon the self-interest of the killer or of a similar nature are not as relevant in the context of active euthanasia performed by a doctor at the request of a patient and subject to appropriate safeguards.

A similar approach was taken some years later in South Australia, when the Criminal Law and Penal Methods Reform Committee in its 1977 Report, *The Substantive Criminal Law*, recommended against the introduction of a separate offence of mercy killing.⁴ Specific consideration was given to a proposal which had earlier been put forward by the English Criminal Law Revision Committee,⁵ that an offence of mercy killing be created to cover circumstances of intentional killing through motives of compassion. However, the South Australian Criminal Law and Penal Methods Reform Committee rejected any attempt to deviate from the criminal law's traditional concern with intention. The committee was of the opinion that the problem of euthanasia cannot be solved by introducing a new concept under which the law takes notice of the motives of the killer to reduce what would be murder or manslaughter to a lesser crime. According to the committee, the only option was to either retain the existing law which treats such cases of intentional killing as murder or manslaughter, or to create some defined exceptions to the class of victims in respect of whom a charge of murder or manslaughter will lie.⁶ Although this latter possibility is of potentially broad application, including

² Law Reform Commissioner of Victoria, Report No. 1, *Law of Murder* (1974) 20.

³ *Id.* 23.

⁴ South Australian Criminal Law and Penal Methods Reform Committee, Fourth Report, *The Substantive Criminal Law* (1977) 57-58.

⁵ Criminal Law Revision Committee, *Working Paper on Offences Against the Person* (1976) paras. 79-87.

⁶ South Australian Criminal Law and Penal Methods Reform Committee, *The Substantive Criminal Law*, 58.

instances of active voluntary euthanasia performed by doctorsⁱ, it was not the subject of any detailed consideration in the committee's report.

Significantly, it is to be noted that although neither the Victorian nor South Australian reform bodies recommended any change to the law, they both acknowledged that lenient treatment of mercy killers would be appropriate.⁷

The subject once again came under review in 1984 by the Victorian Law Reform Commission in the Working Paper, *Murder: Mental Element and Punishment*.⁸ However, the scope of this inquiry was specifically confined to the 'relatively rare instances of mercy killing by family and friends', and it was recognised that different issues are involved in cases of active voluntary euthanasia performed in the medical context. It was suggested that the subject of euthanasia could be reviewed by a committee drawn from a number of disciplines, which would engage in widespread consultation to assess the legal, medical, social and ethical implications of the practice.⁹ Notwithstanding the valuable suggestions made in the working paper, the issues raised therein have not been taken up in the subsequent reports on homicide released by the Victorian Law Reform Commission.¹⁰

Whilst it is undoubtedly of some significance that the issue of mercy killing has been considered in these inquiries, indicating, as it does, recognition of a problem in this area and the possible need for reform, these inquiries are of fairly limited relevance to the more specific issue of legalisation of active voluntary euthanasia performed in the medical context. This is in part because the inquiries have invariably embraced broader criminal law issues, and as a result, the mercy killing issue has never received more than incidental attention. More importantly, however, because of the significant differences which exist between mercy killing and the concept of medically administered active voluntary euthanasia, objections raised or recommendations made with regard to the issue of mercy killing cannot be taken to exhaustively deal with all issues which may arise with regard to active voluntary euthanasia performed in the medical context.

Dying with Dignity, Natural Death, and Passive Euthanasia

Apart from the inquiries into the criminal law, the other major legal development has been the establishment of inquiries in a number of Australian jurisdictions to examine the notion of patients'

⁷ Law Reform Commissioner of Victoria, *Law of Murder*, 20; South Australian Criminal Law and Penal Methods Reform Committee, *The Substantive Criminal Law*, 58. The South Australian report even went so far as to suggest that in some cases it may be appropriate to release such a person on parole immediately after sentence.

⁸ Law Reform Commissioner of Victoria, Working Paper No. 8, *Murder: Mental Element and Punishment* (1984).

⁹ *Id.* 30.

¹⁰ But see Law Reform Commission of Victoria, Report No. 1, *The Law of Homicide in Victoria* (1985) where brief reference was made to cases of compassionate killing to demonstrate the inappropriateness of a mandatory life sentence. Recommendations were made that the sentence for murder be maximum life imprisonment in place of the mandatory life imprisonment, and these recommendations were subsequently implemented in the *Crimes Amendment Act 1986* (Vic.).

rights and medical treatment for the dying.¹¹ Parliamentary or law reform commission inquiries into these issues have been conducted in the States of South Australia, Victoria and Western Australia, with further developments mooted in a number of other jurisdictions.¹² However, the terms of reference for these inquiries, whilst encompassing topics which cover passive euthanasia, have not included the issue of active voluntary euthanasia, either by design or as a result of the way in which they have been interpreted.¹³ These inquiries have nevertheless been significant in promoting public debate on the issue of euthanasia generally and have been instrumental in the introduction of legislation in a number of these jurisdictions which has some bearing on the issue of passive euthanasia.

South Australia

South Australia was the first Australian jurisdiction to move towards reform in this area, with the introduction by the Honourable Frank Blevins M.L.C., of the *Natural Death Bill* in early 1980, by way of a Private Member's Bill. The object of the Bill, which was to a large extent based on natural death legislation introduced in the United States, was to provide statutory means for a person to make a direction that extraordinary measures will not be taken to prolong life, in circumstances where death is imminent from a terminal disease.¹⁴ Under the legislation, the direction would ensure that a patient's right to refuse treatment would apply in circumstances where the patient was no longer able to communicate his or her wishes. This would be achieved by giving statutory recognition to an individual's advance declaration (frequently referred to as a 'living will') directing the withholding of life-sustaining measures in the event of terminal illness or injury. In April 1980, the Bill was referred by the South Australian Legislative Council to a Select Committee for inquiry and report. The Select Committee released its report later that year.¹⁵ The substance of the Bill was unanimously endorsed by the committee subject to a number of recommended changes.¹⁶ An amended *Natural Death Bill* was subsequently introduced and was enacted in 1983.

Natural Death Act 1983 (S.A.)

The *Natural Death Act* 1983 (S.A.) provides that a person of sound mind and over eighteen years of age who desires not to be subjected to 'extraordinary measures'¹⁷ in the event of his or her suffering

¹¹ Note also the National Health and Medical Research Council *Discussion Paper on the Ethics of Limiting Life-Sustaining Treatment* (1988) prepared by the Ethics in Clinical Practice Advisory Panel with the aim of widening community discussion in this area.

¹² In 1985 the Commonwealth Law Reform Commission recommended review of the laws in the Australian Capital Territory in relation to suicide and euthanasia; Law Reform Commission of Australia, First Report, *Community Law Reform for the Australian Capital Territory* (1985) 10-11, 36.

¹³ To date, the only exception has been the South Australian Select Committee Inquiry on the Law and Practice Relating to Death and Dying; see discussion below, 297-301.

¹⁴ Second Reading Speech, S.A. Parl. Deb. (L.C.), Vol. 1, 1982-83, 23 March (1983) 550-551.

¹⁵ South Australian Select Committee of the Legislative Council, *Report on the Natural Death Bill of 1980* (1980).

¹⁶ The Select Committee of the Legislative Council recommended, *inter alia*, inclusion in the legislation of a statement to make it quite clear that natural death is the sole substance of the legislation and that no measure which accelerates or causes death is to be condoned.

¹⁷ Defined in s. 3 to mean 'medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation.'

from a 'terminal illness',¹⁸ may make a direction in the prescribed form and witnessed by two witnesses.¹⁹ Once duly executed, the directive remains effective indefinitely and provides evidence of a person's wishes at a time when they are no longer possessed of decision-making capacity.²⁰ The Act provides that the medical practitioner who is treating the patient is under a duty to act in accordance with the direction unless he or she has reason to believe that the patient has revoked, or intended to revoke, the direction or that at the time of giving the direction, the patient was not capable of understanding the nature and consequences of the direction.²¹ However, the legislation provides no sanction for the failure of the medical practitioner to comply with a patient's direction.²²

The legislation specifically preserves the common law right of a patient to refuse medical treatment.²³ The Act also provides that nothing in the Act authorises an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course.²⁴ This provision was included on the recommendation of the Select Committee, which had felt that it was necessary to make it clear that the legislation in no way promotes active euthanasia.²⁵ The Act also contains a provision regarding causation, providing that for the purposes of the law of South Australia, the non-application or withdrawal of extraordinary measures from a person suffering from a terminal illness does not constitute a cause of death.²⁶ This provision clearly protects a doctor from any liability for withholding or withdrawing extraordinary measures from a terminal patient, and is in fact framed in such general terms that it applies regardless of whether the patient has made a direction under the legislation.²⁷

It is perhaps not surprising that South Australia should have been the first Australian State to introduce such legislation in view of its history of progressive legislative reform. During its passage through parliament²⁸ the legislation was subject to vigorous debate and had attracted considerable

¹⁸ Defined in s. 3 to mean 'any illness, injury or degeneration of mental or physical faculties (a) such that death would, if extraordinary measures were not undertaken, be imminent; and (b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.'

¹⁹ Sections 4(1) and (2). Although the wording of s. 4(1) would appear to suggest that a direction must be made before the diagnosis of a terminal condition, in 1985, the Minister responsible for the legislation, the Honourable Frank Blevins M.L.C., was of the view that a person may make a direction under the legislation at any time; D. Lanham and B. Fehlberg, 'Living Wills and the Right to Die with Dignity' (1991) 18 *Melbourne U.L.Rev.* 329, 338.

²⁰ For materials dealing with the interpretation of the *Natural Death Act* 1983 (S.A.) see, for example, Lanham and Fehlberg; P. Bravender-Coyle, 'South Australia's Natural Death Legislation' (1984) 2 *Lawyer* 18-19; C. Thomson, 'Natural Death Legislation: Some Issues' (1981) *M.J.A.* 451.

²¹ Section 4(3).

²² For criticism of this position see Lanham and Fehlberg, 346-347.

²³ Section 5(1).

²⁴ Section 7(2).

²⁵ See above, n. 16.

²⁶ Section 6.

²⁷ Thomson, 452. For further discussion regarding the scope of this provision, see Lanham and Fehlberg, 348-349.

²⁸ S.A. Parl. Deb. (L.C.), Vol. 1, 1982-83, 30 March (1983) 743-746, 20 April (1983) 895-896; Vol. 2, 1982-83, 4 May (1983) 1110-1111; S.A. Parl. Deb. (H. A.), Vol. 2, 1982-83, 4 May (1983) 1167-1168; Vol. 1, 1983-84, 14 Sep. (1983) 845, 19 Oct. (1983) 1190-1191; Vol. 2, 1983-84, 9 Nov. (1983) 1575-1578, 30 Nov. (1983) 2143-2144.

interest from a number of community groups and organisations.²⁹ Although some members of the medical profession were of the view that prevailing medical practice with regard to the treatment of terminally ill patients was generally satisfactory and that such legislation was therefore unnecessary,³⁰ there appears to have been no major opposition to the legislation either from the medical profession or community groups.

Since its enactment, the Act has attracted criticism on a number of grounds.³¹ Attention has been drawn to the ambiguities in the legislation and the lack of clarity in the terminology used. The legislation has also been criticised for its circumscribed operation, giving effect to a patient's directive only in circumstances where a patient is suffering from a 'terminal illness' and then, only allowing a patient to reject 'extraordinary measures'.³² However, as a result of the saving clause in s. 5(1) the Act clearly does not in any way derogate from the patients' common law right to refuse medical treatment. A more fundamental criticism of the declarations provided for under the legislation is that they involve a refusal of treatment in a wide range of unforeseeable circumstances.³³ Thus, critics argue, the decision to refuse treatment is inevitably uniformed and consequently invalid.

Notwithstanding these shortcomings, the real significance of this legislation is its operation in circumstances where the patient lose competence to make decisions regarding his or her medical treatment. The advance declaration procedure provided for under the legislation allows a patient, while fully conscious and in full control of his or her mental faculties, to give his or her doctor clear directions against prolonging the dying process which will continue to apply even though the patient may become comatose or otherwise lose the capacity to consent to or reject treatment. To this extent, the legislation clarifies the situation which exists at common law.³⁴ However, as noted above, the operation of the legislation is circumscribed by the fact that a declaration is only effective in the event of a terminal condition and only applies in relation to extraordinary measures.³⁵

The legislation is also significant in the protection that it provides to medical practitioners. Although patients clearly have the right at common law to refuse any form of treatment, and doctors are legally obliged to comply with a patient's request, a great deal of uncertainty exists within the medical profession regarding the legality of passive euthanasia, particularly with regard to the withdrawal of

²⁹ See the South Australian Select Committee of the Legislative Council, *Report on the Natural Death Bill of 1980* for reference to the community groups and organisations that had made submissions to the Select Committee.

³⁰ J. Gilligan and J. Linn, 'Natural Death Legislation' (1980) *M.J.A.* 473.

³¹ For a critical evaluation of the living will technique adopted under the *Natural Death Act 1983* (S.A.) see Lanham and Fehlberg, 337-349.

³² Lanham and Fehlberg, 337, 342-345.

³³ For analysis of this criticism, see, for example, the Parliament of Victoria Social Development Committee, Second and Final Report, *Inquiry into Options for Dying with Dignity* (1987) 50 (hereafter referred to as Victorian Social Development Committee Report) and the Law Reform Commission of Western Australian, Project No. 84, Report, *Medical Treatment for the Dying* (1991) 12-14 (hereafter referred to as the Law Reform Commission of Western Australia Report).

³⁴ For discussion of the common law position, see chapter II, n. 55.

³⁵ See above, 295.

artificial life-support measures.³⁶ The effect of the legislation¹ is to provide legal protection to medical practitioners who withhold or withdraw 'extraordinary measures' from a patient even in circumstances where the patient has not made a direction.³⁷ This goes some considerable way in addressing the problem of doctors over-treating patients in order to protect themselves from the risk of liability. The legislation also plays an important educative role, in helping to raise awareness amongst health care personnel and the public generally about the right of a patient to refuse treatment.

The operation of the legislation and in particular, the extent of its use in practice, is more difficult to gauge. A prescribed government form for the making of a directive under the legislation is available to the public free of charge from the South Australian State Information Office and the State Health Commission. Although not entirely satisfied with the legislation, the South Australian Voluntary Euthanasia Society also assists in disseminating information about the Act and the benefits of executing a directive or 'living will'.³⁸ Whilst community awareness and understanding of the legislation has undoubtedly grown since it was first introduced, there have been continuing reports of widespread ignorance amongst the public, and even the medical profession, regarding the existence and operation of the legislation.³⁹ Of particular concern is the mistaken view apparently held by some doctors that if a patient has not made a direction under the Act, then the patient must submit to medical treatment.⁴⁰

South Australian Select Committee on the Law and Practice Relating to Death and Dying

In December 1990, the Member for Coles, opposition back bench, the Honourable Jennifer Cashmore M.H.A. put forward a proposal for the setting up of a committee to inquire into options for dying with dignity.⁴¹ This proposal was adopted and in December 1990, the South Australian House of Assembly appointed a Select Committee on the Law and Practice relating to Death and Dying. The terms of reference for this committee are, *inter alia*, to examine:

³⁶ For example, Victorian Social Development Committee Report, 43-48; Law Reform Commission of Western Australia Report, 4.

³⁷ Section 6(1). Negligence is expressly excluded from this protection; see s. 6(2).

³⁸ The South Australian Voluntary Euthanasia Society (S.A.V.E.S.) had produced a brochure explaining the provisions of the *Natural Death Act* 1983 (S.A.) and providing guidelines for the placement of a Notice of Direction. In addition, the society's newsletters frequently contain information regarding living wills.

³⁹ See, for example, the concerns raised by S.A.V.E.S.; Note, 'The Natural Death Act' (1986) Vol. 3 No. 4 *S.A.V.E.S.Bull.* 5; Note, 'Legal Perspectives' (1987) Vol. 4 No. 2 *S.A.V.E.S.Bull.* 1, 2. These concerns were acknowledged by the Honourable Jennifer Cashmore M.H.A., in connection with the establishment of the South Australian Select Committee on the Law and Practice Relating to Death and Dying (S.A. Parl. Deb. (H.A.), Vol. 2, 1990-91, 6 Dec. (1990) 2453-2455) and have since been borne out by the findings of the Select Committee; see *Interim Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1991) Appendix D, 2 where, in a survey of community opinion, only one person in five was able to say that the South Australian *Natural Death Act* 1983 enabled them to make a living will. See also the *Second Interim Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1992) Appendix E which reported on the views and experiences of general practitioners with regard to the care of the terminally ill, including their knowledge of and approach to the *Natural Death Act* 1983. The findings were that despite the Act being proclaimed some eight years ago, there is still a substantial proportion of general practitioners who are unaware of the provisions of the Act, or who do not make use of it; Appendix E, 9-10.

⁴⁰ Note, 'Legal Perspectives' (1987) Vol. 4 No. 2 *S.A.V.E.S.Bull.* 1, 2.

⁴¹ S.A. Parl. Deb. (H.A.), Vol. 2, 1990-91, 6 Dec. (1990) 2453.

- the extent to which the health services and the present law provide adequate options for dying with dignity;
- whether there is sufficient public and professional awareness of the *Natural Death Act* and if not what measures should be taken to overcome any deficiency; and
- to what extent if any, community attitudes towards death and dying may be changing and to what extent if any the law relating to dying needs to be clarified or amended.⁴²

These terms of reference, particularly the part directing inquiry into whether 'the law relating to dying needs to be clarified or amended,' are broad enough to include the issue of active voluntary euthanasia and have in fact been interpreted by the committee so as to encompass this issue.⁴³ In October 1991, the committee released an interim report⁴⁴ in which it identified amongst the key issues emerging from the inquiry, the view of some people in the community that active voluntary euthanasia should be decriminalised and become an accepted part of medical practice.⁴⁵ Other key issues noted by the committee included: the need for the right to refuse treatment to be well understood; the need for greater awareness, education and availability of palliative care; the need for legal provision enabling people to appoint an agent to make decisions about medical treatment on their behalf if patients themselves become unable to do so; and the need to repeal the *Natural Death Act* and replace it with more appropriate and relevant legislation.⁴⁶

In its second interim report, released in May 1992,⁴⁷ the committee recommended against any change to the law to provide the option of medical assistance in dying.⁴⁸ In rejecting the arguments which had been advanced by the South Australian Voluntary Euthanasia Society in support of the case for legalisation of active voluntary euthanasia, the committee expressed the view that the fact that some patients and doctors may resort to illegal means of ending life is not in itself sufficient justification for legalising the practice.⁴⁹ The committee also rejected the notion that there is no moral distinction between letting someone die and bringing about that person's death.⁵⁰ According to the committee, society has placed significant moral and legal weight on intention and the committee recommended that this distinction should be maintained in the law.⁵¹ Reference was made to evidence put before the

⁴² S.A. Parl. Deb. (H.A.), Vol. 3, 1990-91, 13 Dec. (1990) 2746.

⁴³ S.A. Parl. Deb. (H.A.), Vol. 2, 1990-91, 6 Dec. (1990) 2455 where the Member for Coles, the Honourable Jennifer Cashmore, although personally opposed to the concept of active voluntary euthanasia, forcefully argued against exclusion of the issue from the committee's terms of reference.

⁴⁴ South Australian Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying, *Interim Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1991).

⁴⁵ *Id.* 3.

⁴⁶ *Id.* 2-3.

⁴⁷ South Australian Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying, *Second Interim Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1992).

⁴⁸ *Id.* 51.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

committee regarding the growth of the voluntary euthanasia¹ movement, results of public opinion polls, medical opinion polls and published articles in support of legalisation of active voluntary euthanasia. However, the committee stated that these materials did not persuade it that parliament should legislate in this area, since 'there is a significant difference between the expression of personal support for legalising voluntary euthanasia and acceptance of responsibility for provision in law of this power.'⁵² The committee also noted that:

The fact that there is no precedent in the world for legalised voluntary euthanasia, despite popular pressure in many countries, is evidence of reluctance by even the most radical legislators to adopt a course of action which could have far-reaching and unforeseen consequences.⁵³

Whilst acknowledging the need to relieve the suffering of patients, the committee was of the view that this was not a goal which should be achieved by means of medically assisted death. The committee expressed the belief that if the recommendations made in its report were adopted there would be significant relief of suffering, as well as enhancement of individual dignity, greater comfort for families, and improved development of professional skills.⁵⁴

The greater part of the committee's report was devoted to the other issues which had been identified in the committee's first interim report.⁵⁵ After examining the operation of the *Natural Death Act* 1983 (S.A.), the committee found that although the objectives of the legislation were well supported, there was little understanding, or indeed, knowledge of its provisions.⁵⁶ It also noted the practical difficulties in the operation of the legislation.⁵⁷ The committee therefore recommended that the Act should be replaced by more appropriate legislation, but that any existing certificates executed under the Act should continue to have full force and effect notwithstanding the Act's repeal.⁵⁸ A copy of the proposed legislation, entitled the *Consent to Medical Treatment and Palliative Care Bill* 1992, is included in an Appendix to the report.⁵⁹ In framing alternative legislation, the committee was of the view that it was necessary to clarify the law with regard to the patient's right to refuse treatment and recommended that this right be established by statute. The committee also recommended that legislative provision be made for a medical power of attorney which would come into effect on the legal incapacity of the donor.⁶⁰ Any person over the age of 16 years would be legally able to execute a medical power of attorney. The committee recommended that the power of attorney could be given either in general terms or subject to specific conditions, thereby allowing a person to provide expressly for the withdrawal or retention of extraordinary measures to prolong life or require the

⁵² *Ibid.*

⁵³ *Id.* 52.

⁵⁴ *Ibid.*

⁵⁵ See above, 298.

⁵⁶ *Id.* 3.

⁵⁷ *Id.* 3-4 and see above, 296.

⁵⁸ *Id.* 4. See also Appendix G of the Report, *Consent to Medical Treatment and Palliative Care Bill* 1992.

⁵⁹ *Id.* Appendix G.

⁶⁰ *Id.* 5.

refusal of specific forms of treatment which the person considered inappropriate.⁶¹ The medical agent should be empowered to grant or withhold consent on behalf of the donor for any medical procedure to which the patient could give or withhold consent with the exception that the medical agent may not refuse normal palliative care.⁶² The committee was of the view that whilst a patient may refuse such care for any reason, including a desire to hasten death, such refusal required a level of self-determination which the committee believed could only be exercised by individuals acting consciously, in all the circumstances, on their own behalf.⁶³

The committee also addressed the issue of the legal liability of the medical profession. It recommended that a medical practitioner, or person acting under medical direction, who acts in accordance with the instructions of a patient or his or her agent to withdraw or withhold treatment, should not incur any civil or criminal liability as a result.⁶⁴ It was further recommended that the legislation provide that the provision of palliative care reasonably administered without negligence and with informed consent to a terminally ill patient will not attract criminal or civil liability even if it has the effect of shortening life.⁶⁵ A novel aspect of the committee's deliberations concerned the use of 'do not resuscitate' orders. Recognising the problems in the operation of these orders, which in practice are frequently made without information about the patient's wishes, the committee recommended that this approach be replaced with the adoption of 'good palliative care' orders.⁶⁶ These orders are to be based on consultation with the patient, the family and hospital staff and are intended to be a positive statement of good palliative care directed at patient comfort.⁶⁷ Recommendations were also made regarding the appropriate provision of palliative care and the need for professional education in this area.⁶⁸

Although rejecting the legalisation of active voluntary euthanasia, the committee's report is significant in that it did at least openly address the issue and acknowledged the growing demand for legalisation of the practice. It could be argued that there might have been more complete canvassing of the arguments in support of legalisation, in particular the need for upholding patient self-determination. Essentially, the reasons given for rejecting any change in this area reflect conservative views about the implications of legalisation and concern about untested consequences. Unfortunately, the current Netherlands' experience where active voluntary euthanasia has for some time been practiced by the medical profession with relative openness, was not studied in depth by the committee, though the committee did note concerns which have been expressed about the cumulative impact on that

⁶¹ *Ibid.*

⁶² *Id.* 6. The committee recommended that 'palliative care' should be defined in the Act as measures directed primarily at maintaining or improving the comfort of a patient who is, or would otherwise be, in pain or distress.

⁶³ *Ibid.*

⁶⁴ *Id.* 7.

⁶⁵ *Id.* 8-9. See also Appendix G of the Report, *Consent to Medical Treatment and Palliative Care Bill* 1992, clauses 9 and 10.

⁶⁶ *Id.* 9-11.

⁶⁷ *Ibid.*

⁶⁸ *Id.* 15-27.

society of medically assisted death.⁶⁹ Since the Netherlands is the only jurisdiction where active voluntary euthanasia is practiced by the medical profession with some degree of official acceptance, any serious and comprehensive analysis of the issue of legalisation of active voluntary euthanasia would require a detailed examination of the position in that jurisdiction.⁷⁰

Leaving aside the issue of active voluntary euthanasia, the report is to be welcomed for its recommendations for the repeal of the *Natural Death Act* 1983 (S.A.) and its replacement with wider and more appropriate legislation. In November 1992, the committee released its final report which continues the broad thrust of these recommendations.⁷¹

Victoria

In December 1980, the *Refusal of Medical Treatment Bill* was introduced into the Victorian Parliament by the Honourable Rod Mackenzie M.L.C. as a Private Member's Bill.⁷² This Bill which was along similar lines to the South Australian natural death legislation, was subsequently amended and reintroduced in September 1981; however, debate on the Bill was adjourned and the Bill was never proceeded with. In August 1982, following a change of government, the Minister for Health referred the matter to the Health Advisory Council for consideration with the request that the council comment and report not only on the earlier Bill, but on the wider questions relating to the proposed legislation. In July 1983, the Health Advisory Council released its report, recommending in principle the introduction of refusal of treatment legislation in Victoria and making specific suggestions for amendment to the proposed Bill.⁷³ The proposed legislation had attracted considerable criticism from a number of quarters and no further action was taken by the Victorian Government in relation to this issue until 1985.

Parliament of Victoria Social Development Committee Inquiry. Options for Dying with Dignity

In 1985, the all-party Parliament of Victoria Social Development Committee was given a reference to inquire into a number of issues related to the treatment of dying patients. The committee's terms of reference were potentially far-reaching, including consideration of:

- whether it is desirable and practicable for the Government to take legislative or other action establishing a right to die;
- the fundamental question as to whether, and under what circumstances, if any a person should have a right to die;

⁶⁹ *Id.* 52.

⁷⁰ See chapter VIII.

⁷¹ South Australian Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying, *Final Report of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying* (1992).

⁷² Information received from private correspondence with the Honourable Rod Mackenzie, M.L.C., March 1991.

⁷³ Victorian Health Advisory Council, Report to the Minister of Health, *The Right to Refuse Medical Treatment Bill* (1983).

- the right of an individual to direct that in certain circumstances he or she be allowed to die or assisted in dying and the form which such a direction should take;
- the right of an individual who has not and is incapable of giving such a direction, to be allowed to die, or assisted in dying; and
- the protection for medical, nursing and other professionals who allow an individual to die, or to assist an individual in dying.⁷⁴

The committee's first report took the form of a discussion paper reflecting a range of views on options for dying with dignity which was published at the same time that the committee invited public submissions, with the aim of assisting individuals or groups who wished to participate in the committee's inquiry.⁷⁵ After an extensive period of public consultation,⁷⁶ the committee released its second and final report in 1987.⁷⁷ Although the inquiry was limited to the Victorian jurisdiction, the final report of the Social Development Committee is of much wider significance, being one of the most extensive and comprehensive reviews of its kind ever to be conducted in Australia.

The committee produced no less than 31 recommendations for the consideration of the Parliament of Victoria on a range of matters connected with the inquiry. One of the committee's central deliberations was whether it is desirable and practicable for the government to take legislative or other action establishing a right to die. Although the committee noted general support for the concept of a right to die with dignity,⁷⁸ it found little consensus about what the 'right to die' meant in practice. The evidence before the committee revealed widespread disagreement as to the meaning of the right to die: whether, for example, the right to die was synonymous with the right of a patient to refuse treatment or whether it was a euphemism for euthanasia and mercy killing. Due to both the conceptual and practical difficulties relating to the notion, the committee concluded that it is neither desirable nor practicable to legislate or take other action to establish a right to die.⁷⁹ Specific consideration was given by the committee to the issue of active voluntary euthanasia including analysis of the results of an opinion poll conducted by the Morgan Research Centre in the State of Victoria which had been presented as evidence to the inquiry by the Voluntary Euthanasia Society of Victoria.⁸⁰ Despite public opinion polls indicating support for legalisation of active voluntary euthanasia, as well as many submissions and letters to the committee requesting that active voluntary euthanasia be legalised, the committee concluded that legislation to cover active voluntary euthanasia was not appropriate in Victoria.⁸¹

⁷⁴ Victorian Social Development Committee Report, (xi).

⁷⁵ Parliament of Victoria Social Development Committee, *First Report on Inquiry into the Options for Dying with Dignity* (1986) 7.

⁷⁶ Some 1,400 submissions were received by the Committee (see Victorian Social Development Committee Report, Appendix A), numerous public hearings were held (see Victorian Social Development Committee Report, Appendix B) and the Committee made many visits to hospitals and hospices (see Victorian Social Development Committee Report, Appendix C).

⁷⁷ Parliament of Victoria Social Development Committee, *Second and Final Report on the Inquiry into the Options for Dying with Dignity* (1987).

⁷⁸ *Id.* 138.

⁷⁹ *Id.* 139.

⁸⁰ *Id.* 128-135.

⁸¹ *Id.* 140.

The committee did, however, recommend legislative action clarifying and protecting the existing common law right to refuse medical treatment by the enactment of legislation to establish an offence of medical trespass.⁸² This offence would be established when a medical practitioner carries out or continues with any procedure or treatment which a competent and informed patient has freely refused. The committee was of the view that such legislative action was necessary to combat widespread ignorance and confusion in the community and amongst many medical practitioners, regarding the right of a patient to refuse medical treatment.⁸³ With regard to the issue of medical treatment for incompetent patients, the committee acknowledged the many difficulties in this area and emphasised the value of promoting the enduring power of attorney as a way of enabling people to indicate who is to be responsible for medical decisions on their behalf should they become incompetent in the future.⁸⁴

As a corollary to giving statutory force to the patient's right to refuse treatment, the committee believed it necessary to clarify the legal liability of medical practitioners who withhold or withdraw medical treatment or life-support systems. It was accordingly recommended that the legislation encompass protection from criminal and civil liability on the part of a medical practitioner who acts in good faith and in accordance with the expressed wishes of the fully informed, competent patient who refuses medical treatment or procedures.⁸⁵ It was further recommended that the non-application of medical treatment does not in itself constitute the cause of death, where a medical practitioner is acting in good faith to avoid committing the offence of medical trespass.⁸⁶

A number of the committee's other terms of reference, directing inquiry, *inter alia*, into the right of an individual to be 'assisted in dying', were interpreted by the committee as not encompassing euthanasia.⁸⁷ Although arguably broad enough to permit consideration of active voluntary euthanasia as a form of assistance in dying, these particular terms of reference were read down by the committee so as to exclude consideration of active voluntary euthanasia. This represented a fairly significant limitation on the scope of the committee's inquiry, virtually foreclosing serious consideration of the issue. Although the question of active voluntary euthanasia had admittedly been given some consideration in the context of the committee's inquiry regarding a 'right to die', the inherent vagueness of that concept inevitably led to rejection of any proposal to legislate in favour of active voluntary euthanasia.

The report of the Social Development Committee was generally welcomed by medical and church groups, particularly for its recommendation that no legislative action to be taken to establish a right

⁸² *Id.* 140-141.

⁸³ *Id.* 99, 101-104.

⁸⁴ *Id.* (viii) (Recommendation No. 21), 193-199.

⁸⁵ *Id.* 140-141.

⁸⁶ *Id.* 143.

⁸⁷ *Id.* 155-156.

to die.⁸⁸ Opposition to the committee's recommendations came principally from right to life groups, which alleged that the inquiry and subsequent report were pro-euthanasia.⁸⁹

The first government initiative in response to the committee's report was the *Medical Treatment Bill* 1987 (Vic.) which was introduced into parliament in October 1987. The Bill sought to give statutory force to the common law right of a patient to refuse treatment by setting out a refusal of treatment certificate procedure. In order to provide some means for the enforcement of this right, the Bill proposed the enactment of the offence of medical trespass to apply in circumstances where a doctor undertakes treatment after a refusal of treatment certificate has been signed by the patient. The Bill also sought to provide legal protection to medical practitioners acting in accordance with a patient's refusal of treatment certificate. Further, the Bill made provision for an individual to appoint an agent to make decisions about medical treatment, in the event that the individual became incompetent. This latter provision had come about as a result of doubts raised after the committee's report had been tabled in parliament, as to whether the existing enduring power of attorney mechanism (introduced into Victorian legislation by amendments to the *Instrument Act* 1958 (Vic.) in 1981) was able to be used to give an agent authority in respect of health care matters.⁹⁰ Because of these doubts, and in accordance with the general spirit of the committee's report,⁹¹ it was decided to include a provision for an enduring power of attorney in the legislation. Following the introduction of the Bill in October 1987, some amendments were made of a clarifying or technical nature and the Bill was renamed the *Medical Treatment Bill (No 2)* 1988.⁹²

Whilst there was widespread community support for the Bill, even amongst church groups,⁹³ the proposed legislation provoked a stormy response from right to life organisations. The President of Right to Life Victoria, Margaret Tighe, claimed that the Bill promoted passive euthanasia and stated that it would therefore be vigorously opposed by her organisation.⁹⁴ The Australian Medical Association (A.M.A.) was also opposed to the introduction of legislation, particularly the creation of an offence of medical trespass, claiming that the changes were an unnecessary intrusion into the doctor-patient relationship.⁹⁵

It had originally been anticipated that the Bill would receive support from the opposition party since it was largely based on the recommendations of the all-party Parliamentary Committee which the opposition had endorsed. However, in April 1988, the shadow Attorney-General, Mr Chamberlain,

⁸⁸ The *Age* 1 May 1987.

⁸⁹ *Ibid.*

⁹⁰ Vic. Parl. Deb. (L.C.), Vol. 389, 28 Oct. (1987) 1029.

⁹¹ See Victorian Social Development Committee Report, (viii), Recommendation No. 21. and discussion at 193-199.

⁹² Vic. Parl. Deb. (L.C.), Vol. 390, 23 March (1988) 332-336.

⁹³ The legislation received support from the Roman Catholic and Anglican Archbishops of Melbourne; see the *Sun* 21 March 1988; the *Advocate* 24 March 1988; the *Age* 7 April 1988.

⁹⁴ Note, 'Medical Treatment Act' (1988) Vol. 7 No. 4 *Bioethics News* 1, 2.

⁹⁵ The *Australian* 13 Oct. 1987; the *Herald* 14 Oct. 1987; the *Age* 14 Oct. 1987. Opposition also came from individual doctors; see, for example, the advertisement placed in the *Age* 3 May 1988 opposing the *Medical Treatment Bill* and signed by 63 doctors.

announced that the Bill was 'fraught with uncertainties and dangers and would not be supported by the opposition'.⁹⁶ Particular concern was expressed about the operation of the enduring power of attorney provisions which had been included in the legislation, although they had not been part of the recommendations of the Social Development Committee.⁹⁷ The Liberal Party's decision to oppose the legislation quickly met with condemnation and prompted a number of community leaders, led by the Vice-Chancellor of Melbourne University, Professor Penington, to urge opposition members to cast a conscience vote and support the legislation rather than reject it for political reasons.⁹⁸ It was claimed that the Liberal party had succumbed to pressure from right to life groups and was greatly misreading the community mood with regard to the legislation.⁹⁹

The legislation was only saved from defeat when a senior liberal member of parliament, the Honourable Alan Hunt M.L.C., defied his party and abstained from voting against the Bill.¹⁰⁰ This meant that the Bill could proceed to the crucial committee stage, allowing opportunity for consideration and debate on the merits of the Bill. However, in the committee debate, Mr Hunt voted with his party to reject the clause which would have allowed patients to appoint an agent to refuse treatment on their behalf if they become incompetent.¹⁰¹ The Bill was subsequently passed after the controversial provision had been deleted. The agency provision was in fact one of the few innovations under the legislation, and the failure of this initiative came as a great disappointment to proponents of the legislation. The then Victorian Attorney-General responded to the Liberal aboutface by announcing that the form of the legislation passed by parliament was not acceptable to the government, and, that while the government intended to proclaim those parts of the original Bill which had been passed, it would move to reintroduce those provisions deleted by the opposition.¹⁰²

Medical Treatment Act 1988 (Vic.)

The *Medical Treatment Act* 1988 (Vic.), which came into operation on the 1st of September 1988, clarifies the law relating to the right of patients to refuse medical treatment by establishing a procedure whereby a patient can, by certificate, clearly indicate a decision to refuse medical treatment.¹⁰³ 'Palliative care'¹⁰⁴ is specially excluded from the operation of the legislation.¹⁰⁵ The

⁹⁶ *The Age* 14 April 1988; Vic. Parl. Deb. (L.C.), Vol. 390, 19 April (1988) 682-703.

⁹⁷ *Ibid.*

⁹⁸ *The Australian* 16-17 April 1988.

⁹⁹ *The Age* 20 April 1988.

¹⁰⁰ *The Sydney Morning Herald* 6 May 1988. See also Vic. Parl. Deb. (L.C.), Vol. 391, 3 May (1988) 1041.

¹⁰¹ Vic. Parl. Deb. (L.C.), Vol. 391, 5 May (1988) 1272-1281, 1298.

¹⁰² Note, 'Dying with Dignity' (1988) 14 *C'wlth. Law Bull.* 1504.

¹⁰³ Note also s. 1 which outlines the purposes of the legislation. For analysis of the legislation, see D. Lanham, 'The Right to Choose to Die with Dignity' (1990) 14 *Crim.L.J.* 401, 424-430. Note also K. Andrews, 'The Medical Treatment Act' (1989) 150 *M.J.A.* 31.

¹⁰⁴ Defined in s. 3 to include (a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or (b) the reasonable provision of food and water.

¹⁰⁵ Section 4(2). This provision was the product of an amendment made to the original *Medical Treatment Bill* 1987 in response to concern from representatives from the Catholic Church; the *Advocate* 31 March 1988.

patient's common law right to refuse treatment is preserved by virtue of s. 4(1) which provides that the Act does not affect any right of a person under any other law to refuse medical treatment.¹⁰⁶

A central feature of the Act is the refusal of treatment certificate, the procedure for which is set out in s. 5. Section 5(1) provides that:

If a medical practitioner and another person are each satisfied-

- (a) that the patient has clearly expressed or indicated a decision-
 - (i) to refuse medical treatment generally, or
 - (ii) to refuse medical treatment of a particular kind-
for a current condition; and
- (b) that the patient's decision is made voluntarily and without inducement and compulsion; and
- (c) that the patient has been informed about his or her condition to an extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment generally or of particular kind (as the case requires) for that condition and that the patient has appeared to understand that information and
- (d) that the patient is of sound mind and has attained the age of 18 years-

the medical practitioner and the other person may together witness a refusal of treatment certificate.

In order to be effective, a refusal of treatment certificate must be in the form of Schedule 1.¹⁰⁷ The terms 'medical practitioner', 'medical treatment' and 'refusal of treatment certificate' are defined under the legislation.¹⁰⁸ It is clear from the wording of s. 5(1)(a) that a patient can only refuse medical treatment for a current condition. In this regard, the legislation differs from the situation under the present South Australian legislation. As a certificate under the *Medical Treatment Act* 1988 (Vic.) must relate to a current condition, it cannot be used as a living will to refuse treatment generally in advance of the onset of illness or disease.¹⁰⁹ However, in other respects, the *Medical Treatment Act* 1988 (Vic.) is broader than the South Australian *Natural Death Act* 1983 in that its operation is not limited to terminal patients. Under the Victorian legislation, patients can refuse any medical treatment (with the exception of palliative care), whereas under the South Australian legislation, only extraordinary measures can be refused in the event of terminal illness.¹¹⁰

Under the *Medical Treatment Act* 1988 (Vic.) a refusal of treatment certificate can be cancelled by the patient¹¹¹ and will automatically cease to apply if the medical condition of the person has changed to

¹⁰⁶ The patient's right to refuse palliative care at common law is therefore preserved.

¹⁰⁷ Section 5(2).

¹⁰⁸ Section 3.

¹⁰⁹ Andrews, 32.

¹¹⁰ As outlined above, recommendations have been made by the South Australian Select Committee on the Law and Practice Relating to Death and Dying for the repeal and replacement of the South Australian *Natural Death Act* 1983. See above, 299.

¹¹¹ Sections 7(1)&(2). For Notice of Cancellation, see also Schedule 1 as amended by the *Medical Treatment (Enduring Power of Attorney) Act* 1990 (Vic.). Prior to the *Medical Treatment (Enduring*

such an extent that the condition in relation to which the certificate was given is no longer current.¹¹²

Section 6 of the Act seeks to give statutory force to the refusal of treatment certificate by creating the offence of medical trespass. That section provides that a medical practitioner must not, knowing that a refusal of treatment certificate applies to a person, undertake or continue to undertake any medical treatment to which the certificate applies, being treatment for the condition in relation to which the treatment certificate was given.¹¹³ In this respect, the legislation goes beyond the *Natural Death Act* 1983 (S.A.), or for that matter the newly proposed *Consent to Medical Treatment and Palliative Care Bill* 1992 (S.A.), which provide no sanction for the failure of a medical practitioner to comply with a patient's directive.

The right of a patient to refuse treatment under the legislation is reinforced by s. 9 which confers protection on medical practitioners who act in accordance with a patient's refusal of treatment certificate. The section provides that a medical practitioner or a person acting under the direction of a medical practitioner who, in good faith and in reliance on a refusal of treatment certificate, refuses to perform or continue medical treatment which he or she believes on reasonable grounds has been refused in accordance with this Act is not-

- (a) guilty of misconduct or infamous conduct in a professional respect; or
- (b) guilty of an offence; or
- (c) liable in any civil proceedings-

because of the failure to perform or continue that treatment.¹¹⁴

Thus, medical practitioners who, in good faith, act in accordance with a patient's refusal of treatment certificate are clearly protected from professional, criminal and civil liability.

While the introduction of the *Medical Treatment Act* 1988 (Vic.) was undoubtedly significant, clarifying and reinforcing the right of a patient who has decision-making capacity to refuse medical treatment, its major shortcoming was the absence of a mechanism providing for decision-making in the event of supervening incompetence. As noted earlier, the original *Medical Treatment Bill* 1987 (Vic.) had provided for the issue of supervening incompetence by allowing for the appointment of an agent to make decisions about medical treatment, but the opposition had forced the deletion of these crucial provisions from the Bill.¹¹⁵

Power of Attorney) Act 1990 (Vic.), the *Medical Treatment Act* 1988) (Vic.) also allowed for the modification of a refusal of treatment certificate.

¹¹² Section 7(3).

¹¹³ Section 6 as amended by the *Medical Treatment (Enduring Power of Attorney) Act* 1990 (Vic.) (consequential amendment only).

¹¹⁴ *Ibid.*

¹¹⁵ See above, 305.

Medical Treatment (Enduring Power of Attorney) Act 1990 (Vic.)

In 1990, significant amendments were made to the *Medical Treatment Act 1988* (Vic.) with the enactment of the *Medical Treatment (Enduring Power of Attorney) Act 1990* (Vic.) dealing with decision-making on behalf of incompetent patients.¹¹⁶ This legislation had its origins in the agency provisions of the initial *Medical Treatment Bill*, but these earlier proposals had undergone substantial revision in order to incorporate appropriate safeguards against abuse of authority. The *Medical Treatment (Enduring Power of Attorney) Bill 1989* (Vic.) was first introduced into the Victorian Parliament in May 1989 and was eventually passed in April 1990. It received support from all parties in the Victorian Parliament, but members of the Liberal Party and the National Party were allowed a conscience vote.¹¹⁷

The *Medical Treatment (Enduring Power of Attorney) Act 1990* (Vic.) complements the *Medical Treatment Act 1988* (Vic.) by conferring upon incompetent patients the right to refuse medical treatment. This is achieved by extending the scope of the legislation so that in circumstances where the patient becomes incompetent, decisions to refuse medical treatment can be made on behalf of the patient either by an agent appointed under an Enduring Power of Attorney (Medical Treatment) or by a guardian appointed under the *Guardianship and Administration Board Act 1986* (Vic.).¹¹⁸

The key feature of the legislation is that, by way of amendment to the *Medical Treatment Act 1988* (Vic.), it provides a procedure whereby a person can appoint an agent to make decisions on his or her behalf in the event that he or she becomes incompetent.¹¹⁹ The Act provides that the appointment of an agent shall be by way of enduring power of attorney (medical treatment) in accordance with Schedule 2 of the legislation and takes effect if and only if the person giving the power becomes incompetent.¹²⁰ However, once the person becomes incompetent, the decision-making power of the agent operates in much the same way as when a competent patient refuses treatment: a medical practitioner and an independent witness must be satisfied that the agent has been informed about the nature of the patient's current condition and that the agent understands that information.¹²¹ In order to protect against potential abuse, the legislation contains a number of additional preconditions which must be satisfied before an agent or guardian can complete a refusal of treatment certificate on behalf of an incompetent patient. These are contained in the new s. 5B(2) which provides that an agent or

¹¹⁶ For analysis of this legislation, see D. Lanham and S. Woodford, 'Refusal by Agents of Life-Sustaining Medical Treatment' (1992) 18 *Melbourne U.L.Rev.* 659.

¹¹⁷ The legislation was passed 65 votes to 16 after members of the Liberal Party and the National Party were allowed a conscience vote; Note, 'Medical Treatment Enduring Power of Attorney Act' (1990) Vol. 9 No. 4 *Bioethics News* 1.

¹¹⁸ See *Medical Treatment (Enduring Power of Attorney) Bill 1989* (Vic.) Explanatory Memorandum.

¹¹⁹ See new s. 5A inserted into the *Medical Treatment Act 1988* (Vic.) In addition to the agency situation, a decision about medical treatment of a person may be made in accordance with the legislation if the person is a represented person and an appropriate order has been made under the *Guardianship and Administration Board Act 1986* (Vic.) providing for decisions about medical treatment by the person's guardian; see s. 5A(1)(b).

A further amendment has recently been made to the *Medical Treatment Act 1988* (Vic.) by the enactment of the *Medical Treatment (Agents) Act 1992* (Vic.) which enables a person to appoint an alternate agent to make decisions about the medical treatment of the person if the person becomes incompetent and the agent is unable or unavailable to act.

¹²⁰ Section 5A(2)(b).

¹²¹ Section 5B.

guardian may only refuse medical treatment on behalf of a patient if: (a) the medical treatment would cause unreasonable distress to the patient; or, (b) there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and wellbeing, would consider that the medical treatment is unwarranted. As a further safeguard against the risk of abuse, s. 5C enables the Guardianship and Administration Board, on the application of the Public Advocate, or a person who has a special interest in the affairs of the donor of the power, to suspend or revoke an enduring power of attorney (medical treatment) in the interests of the donor of the power.

Another amendment to the *Medical Treatment Act 1988* (Vic.), of general application, is the insertion of new s 5F which provides that a person forfeits any interest they may have under a will, instrument or intestacy of another person, in circumstances where they have procured or obtained the execution of a certificate under the Act by that other person by deception, fraud, misstatement or undue influence. Further, in order to eliminate any suggestion that the *Medical Treatment Act 1988* (Vic.), as amended, will legitimise medical homicide or facilitate 'euthanasia by neglect', the Act specifically provides, both in its statement of purposes, as well as in the substantive provisions, that the Act does not affect the operation of the *Crimes Act 1958* (Vic.) with regard to assisting suicide¹²² or homicide.¹²³

The *Medical Treatment (Enduring Power of Attorney) Act 1990* (Vic.) effects an important extension to the law in Victoria by amending the *Medical Treatment Act 1988* (Vic.) so as to provide a mechanism whereby a person who is competent can appoint an agent by way of enduring power of attorney to make medical decisions on his or her behalf in the event of supervening incompetence. The legislation thereby addresses an issue which has been the subject of considerable legal uncertainty and community concern.¹²⁴ Significantly, this is also one of the key issues which is now being addressed in South Australia where it has been recommended that legislation be introduced to replace the *Natural Death Act 1983* (S.A.) to provide for the appointment of a medical power of attorney.¹²⁵

Although there have been some outspoken critics of the legislative developments which have taken place in Victoria through the enactment of the *Medical Treatment Act 1988* (Vic.) and its subsequent amendment by the *Medical Treatment (Enduring Power of Attorney) Act 1990* (Vic.),¹²⁶ the legislation has generally been well received. It has been hailed by some commentators as an important piece of reform, the full benefits of which are yet to be realised once more people become appraised of their rights under the legislation.¹²⁷ In order to ensure smooth implementation of the legislation, the Victorian Government established an Implementation Committee under the auspices of the Public

¹²² For discussion see D. Mendelson, 'The *Medical Treatment (Enduring Power of Attorney) Act* and Assisted Suicide: The Legal Position in Victoria' (1992) Vol. 12 No. 1 *Bioethics News* 34.

¹²³ See s. 1 setting out the purposes of the Act, also s. 6, amending s. 4(2) of the *Medical Treatment Act 1988* (Vic.).

¹²⁴ See chapter II, n. 55.

¹²⁵ See discussion above, 299-300.

¹²⁶ For example, K. Clarke, 'The Medical Treatment Act 1988: Safeguarding Patient Rights or Risking Patient Welfare?' (1989) 63 *Law Inst.J.* 473.

¹²⁷ For commentators in support of the legislation see, for example, Lanham, 'The Right to Choose to Die with Dignity'; G.P. Smith, 'Re-Thinking Euthanasia and Death with Dignity: A Transnational Challenge' (1990) 12 *Adel.L.Rev.* 480, 481-482.

Advocate. This committee, comprising representatives of hospitals, leading professions and community representatives, has initiated an education program within the health professions and the community generally, including preparation of explanatory notes providing guidance to the Act, administrative guidelines for hospitals, copies of documents required under the Act and a pamphlet for the public.

Australian Capital Territory

Apart from Victoria, the only other jurisdiction to have introduced legislation which provides for the appointment of an agent to make medical treatment decisions on behalf of the principal in the event of the principal's incapacity is the Australian Capital Territory.¹²⁸ Pursuant to the recommendations of the Australian Law Reform Commission,¹²⁹ the *Powers of Attorney Act* of 1956 (A.C.T.) was amended by the *Powers of Attorney Amendment Act* 1989 (A.C.T.) *inter alia*, to permit a person to confer upon an agent, by way of enduring power of attorney, the power to consent to medical treatment. The legislation is, however, couched in fairly limited terms, enabling the agent to consent on behalf of the donor to medical treatment which is necessary for the well-being of the donor,¹³⁰ or the donation of a body part, blood or tissue of the donor to another person in accordance with the *Transplantation and Anatomy Act* 1978 (A.C.T.),¹³¹ while the donor is incapacitated.¹³² The exact ambit of this provision is somewhat uncertain. Since the legislation refers only to the power to consent to medical treatment on behalf of the donor and is silent on the issue of refusal of medical treatment, on a strict interpretation of the legislation it could be argued that it does not extend to the refusal of medical treatment. A more flexible interpretation, on the other hand, would hold that the power to consent to medical treatment necessarily includes the power also to *reject* treatment on behalf of the donor.¹³³ On the assumption that the legislation does extend to the refusal of medical treatment on behalf of the donor, as in Victoria, this introduces an important extension to the law, enabling a person to appoint another to make health care decisions on his or her behalf in the event that he or she loses decision-making capacity.

Northern Territory

To date, the Northern Territory is the only other Australian jurisdiction to have introduced legislation in this area with the enactment of the *Natural Death Act* 1988 (N.T.). In August 1988 a Bill closely modelled on the South Australian *Natural Death Act* 1983 was introduced into the Northern Territory Parliament. Drafts of the legislation had been circulated to church representatives, community groups

¹²⁸ The Law Reform Commission of Western Australia has recommended that Western Australia introduce legislation providing for an enduring health care power of attorney; see below, 312. Although enduring power of attorney legislation now exists in all Australian jurisdictions, (R. Creyke, 'Enduring Powers of Attorney: Cinderella Story of the 80's' (1991) 21 *W.Aust.L.Rev.* 122.) it would appear not to extend to the area of medical treatment in the absence of specific provision to this effect.

¹²⁹ Community Law Reform for the Australian Capital Territory, Third Report, *Enduring Powers of Attorney* (1987) 25-26.

¹³⁰ Section 13(1)(b)(i).

¹³¹ Section 13(1)(b)(ii).

¹³² Section 13(2)(a).

¹³³ Support for this view could be drawn from the fact that discussion in the area of 'informed consent' is understood to refer to the right of a patient to consent to and also to refuse medical treatment.

and the medical profession by the Northern Territory Attorney-General, but no objections were received.¹³⁴ The Bill was subsequently enacted with apparent ease, introducing into the Northern Territory a statutory mechanism based on the South Australian model pursuant to which a competent person can give directions against the artificial prolongation of the dying process through the use of 'extraordinary measures' in the event of 'terminal illness' which are to apply in the event that he or she becomes incompetent.¹³⁵ Given the similarity between this Act and the South Australian *Natural Death Act* 1983 upon which it is based, the comments made earlier in relation to the latter act are also relevant here.¹³⁶ It is, in all the circumstances, somewhat ironic that the South Australian legislative model was adopted in the Northern Territory not that long before its repeal was recommended in South Australia.¹³⁷

Western Australia

In response to concerns about legal uncertainties involved in the treatment of the terminally and incurably ill, the Western Australian Law Reform Commission was asked to consider and report on the civil and criminal law relating to medical treatment for the dying. The commission's terms of reference were:

To review the criminal and civil law so far as it relates to the obligations to provide medical or life supporting treatment to persons suffering conditions which are terminal or recovery from which is unlikely and, in particular, to consider whether medical practitioners or others should be permitted or required to act upon directions by such persons against artificial prolongation of life.¹³⁸

In June 1988, the commission issued a discussion paper and invited public comment on the matters raised therein.¹³⁹ Comments were received from a large number of individuals and organisations. The commission's report was released in February 1991. It is clear from the commission's terms of reference, that the scope of the inquiry was limited to the issue of withholding or withdrawing treatment from dying patients. Thus, as the commission noted in the introduction to the report, the reference does not cover active euthanasia in the sense of the application of a procedure or treatment with the deliberate intention to terminate life.¹⁴⁰

¹³⁴ N.T. Parl. Deb. (L.A.), Vol. 27, 11 Oct. (1988) 87.

¹³⁵ *Natural Death Act* 1988 (N.T.).

¹³⁶ See above, 295-297. One material difference between the *Natural Death Act* 1988 (N.T.) and the *Natural Death Act* 1983 (S.A.) is in the scope of s. 6 dealing with cause of death. Under the Northern Territory legislation, the non-application or withdrawal of extraordinary measures from a person suffering from a terminal illness does not constitute a cause of death where the non-application or withdrawal was as a result of and in accordance with a direction made under the legislation. The South Australian provision is much wider, containing a blanket statement to the effect that the non-application or withdrawal of extraordinary measures from a person suffering from a terminal illness does not constitute a cause of death and there is no requirement that the non-application or withdrawal of treatment was done pursuant to a direction from the patient under the legislation. For further discussion, see chapter I, 27.

¹³⁷ See above, 299.

¹³⁸ Law Reform Commission of Western Australia, Project No. 84, Discussion Paper, *Medical Treatment for the Dying* (1988) 5 (hereafter referred to as the Law Reform Commission of Western Australia Discussion Paper.)

¹³⁹ *Ibid.*

¹⁴⁰ Law Reform Commission of Western Australia, Report, 2.

One of the principal issues before the commission concerned the legal uncertainty within the medical profession regarding the legality of withholding or withdrawing life-support, even at the request of a competent patient, in the light of the legal duties imposed by the *Criminal Code* 1913 (W.A.).¹⁴¹ The commission was of the view that although doctors' fears of prosecution are more apparent than real, a strong case can nevertheless be made out for the enactment of legislation in Western Australia to clarify the rights of patients, along similar lines to that introduced in Victoria by virtue of the *Medical Treatment Act* 1988.¹⁴² The commission thought that this was necessary to allay the concern and uncertainty amongst many members of the medical profession regarding the legality of their actions which may inhibit doctors from providing the most appropriate medical care.¹⁴³ The basic principle underlying the commission's deliberations was the patient's right of self-determination.¹⁴⁴ Whilst acknowledging that the common law already gives proper recognition to the principle that a person has the right not to be treated without consent, the commission recommended that adult patients should be able to complete a refusal of treatment certificate as a means of providing proof of a refusal of treatment.¹⁴⁵ Drawing upon the Victorian model, it was recommended that the offence of medical trespass be created to apply in circumstances where a doctor who, knowing that a refusal of treatment certificate has been executed, undertakes or continues to undertake any medical treatment to which the certificate applies. Further, it was recommended that doctors acting in good faith in reliance on a refusal of treatment certificate should be protected from civil or criminal liability for failing to provide or continue treatment.¹⁴⁶

The other principal issue addressed by the commission was the need to provide a means by which persons can make provision for their future medical treatment in the event that they become incompetent and are unable to make these decisions for themselves.¹⁴⁷ The legislative approach favoured by the commission was that adopted in Victoria pursuant to the *Medical Treatment (Enduring Power of Attorney) Act* 1990 which allows a person to execute an enduring power of attorney, appointing an agent to make treatment decisions on his or her behalf should he or she become unable to do so. The commission accordingly recommended that similar legislation be introduced in Western Australia.¹⁴⁸

It should be noted that notwithstanding the fairly narrow terms of reference, the commission's recommendations with regard to these matters are not limited to 'persons suffering conditions which are terminal or recovery from which is unlikely' and are in fact capable of applying to all kinds of patients.¹⁴⁹

¹⁴¹ Law Reform Commission of Western Australia Discussion Paper 6, 12-17; Law Reform Commission of Western Australia Report, 3-7.

¹⁴² Law Reform Commission of Western Australia Report, 8-9.

¹⁴³ *Id.* 8.

¹⁴⁴ *Id.* 9.

¹⁴⁵ *Id.* 9, 21-22.

¹⁴⁶ *Id.* 24.

¹⁴⁷ *Id.* 10-20.

¹⁴⁸ *Id.* 15-20.

¹⁴⁹ *Id.* 32.

Another area of concern addressed by the commission was the issue of pain control care given to terminally ill patients which may have the effect of accelerating the patient's death.¹⁵⁰ The commission was of the view that as the existing law is uncertain and is capable of leading to inhumane treatment of terminally ill patients, it ought to be amended.¹⁵¹ The commission recommended that doctors should not be criminally or civilly liable for administering drugs or other treatment for the purpose of controlling or eliminating pain and suffering, even if the drugs or other treatment incidentally shorten the patient's life, provided that the consent of the patient (or the patient's agent or guardian if the patient is not competent) is obtained and the administration of the drug or treatment is reasonable in all the circumstances.¹⁵² At the time of writing, the recommendations made by the commission had not been implemented.

Tasmania

In Tasmania, repeated efforts have been made by the Honourable Dr Bob Brown, Independent M.H.A., to introduce natural death legislation by way of a Private Member's Bill. A Bill, in identical terms to the South Australian *Natural Death Act* 1983, was first introduced into the Tasmanian Parliament in 1985 with the aim of providing for and giving legal effect to directions against artificial prolongation of the dying process.¹⁵³ Dr Brown claimed to have received widespread community support for the legislation, evidenced by a 1985 Tasmanian public opinion poll which indicated that more than 80% of the Tasmanian public were in favour of the legislation.¹⁵⁴ However, following the Second Reading Speech, the then Liberal government successfully sought a 12 month adjournment of the debate, ostensibly to allow adequate time for full consideration of all the issues.¹⁵⁵ Opposition to the Bill came principally from right to life groups.¹⁵⁶ The A.M.A. (Tas. Branch), whilst not opposing the legislation outright, expressed doubts about whether the legislation was necessary.

When the Bill was reintroduced in 1986, it was opposed by the government on the grounds that there was no legal definition of death in Tasmania. Although a statutory definition of death was

¹⁵⁰ *Id.* 25-27.

¹⁵¹ *Id.* 26.

¹⁵² *Id.* 26-27. See also the recommendations of the Queensland Criminal Code Review Committee in its Interim Report, *First Interim Report of the Criminal Code Review Committee* (1991). Clause 69 provides that a person is not criminally responsible if he or she gives such palliative care as is reasonable in the circumstances, for the control or elimination of a person's pain and suffering even if such care shortens that person's life, unless the patient refuses such care. This recommendation was based on the recommendations of the Law Reform Commission of Canada in its 1987 revision of the Canadian *Criminal Code*; see below, 345-347. The South Australian Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying has made similar recommendations; see above, 300.

¹⁵³ *Natural Death Bill* 1985 (Tas.). See Second Reading Speech, Tas. Parl. Deb. (H.A.), Vol. VII, 21 March (1985) 552-553.

¹⁵⁴ See Tasmanian Opinion Polls, 23 Feb. 1985. Respondents were asked: 'Do you support legislation giving the right to die? That is, giving the individual of sound mind the right to choose whether extraordinary measures are taken to preserve his/her life?' Of the respondents, 80.9% answered yes, 13.1% answered no and 6.1% were undecided.

¹⁵⁵ Tas. Parl. Deb. (H.A.), Vol. VII, 21 March (1985) 552-557; 28 March (1985) 797-801.

¹⁵⁶ Tasmanian Right to Life Association, Right to Life Australia..

subsequently enacted,¹⁵⁷ the government continued to oppose the legislation.¹⁵⁸ A proposal, moved by the then Labor opposition in November 1987, to establish a Select Committee to inquire into and report upon the need for such legislation also failed to gain the necessary support in the parliament.¹⁵⁹

The *Natural Death Bill* was reintroduced by Dr Brown in April 1990, but was subsequently withdrawn and replaced with the *Medical Treatment and Natural Death Bill* 1990 based upon the Victorian *Medical Treatment Act* 1988.¹⁶⁰ The extensions which have subsequently been made to the Victorian legislation, by virtue of the enactment of the *Medical Treatment (Enduring Power of Attorney) Act* 1990 (Vic.), were not contained in this Bill. The shift in the proposed legislation from the South Australian to the Victorian model represents a significant change in direction from what is essentially living will legislation to legislation which, although in some respects of broader application,¹⁶¹ simply confirms and supports the existing right of a patient to refuse medical treatment through the refusal of treatment certificate procedure and the creation of the offence of medical trespass. In the absence of the enduring power of attorney provisions, this Bill did not address the situation of patients who wish to make provision for their future medical treatment in the event that they lose decision-making capacity.

As a result of support for the legislation from the then Labor government, the Private Member's Bill was passed by the House of Assembly in December 1990. It was, however, defeated in the Legislative Council in July 1991.¹⁶² Dr Brown has since reintroduced this legislation.¹⁶³

New South Wales

In recent years, consideration has been given in New South Wales to the introduction of legislation to give legal effect to directions against artificial prolongation of the dying process. These developments were largely precipitated by concern in that jurisdiction regarding the legal liability of doctors for withholding or withdrawing treatment from patients. The issue of legal liability had arisen in the context of the development of guidelines and protocols by a number of Sydney hospitals to assist medical staff on the issue of withdrawing life-support or withholding life-saving treatment from seriously ill patients, and, in particular, with regard to the legality of implementing a 'not-for-resuscitation' policy in respect of certain patients.¹⁶⁴ The matter was brought to the attention of the

¹⁵⁷ *Human Tissue Amendment Act* 1987 (Tas.), amending the *Human Tissue Act* 1985 (Tas.).

¹⁵⁸ When first introduced, the Labor opposition had supported the Bill in principle but called for further public debate. However, the Labor opposition subsequently joined with the government to oppose the Bill.

¹⁵⁹ Tas. Parl. Deb. (H.A.), Vol. IX, 26 Nov. (1987) 5371-5373; 10 Dec. (1987) 5619-5623.

¹⁶⁰ See Dr Brown, Second Reading Speech, Tas. Parl. Deb. (H.A.), Vol. XII, 22 Nov. (1990) 5300-5302 where he explains that there was preference from some quarters for the Victorian legislative model over the South Australian legislation.

¹⁶¹ See above, 306.

¹⁶² Tas. Parl. Deb. (L.C.), Vol. XIII, 15 July (1991) 1856-1876.

¹⁶³ *Medical Treatment and Natural Death Bill* 1992.

¹⁶⁴ The Eastern Sydney Area Health Service had obtained legal advice regarding the implementation of a 'not-for-resuscitation' (N.F.R.) policy. This advice, which was subsequently made public, indicated that non-action pursuant to a N.F.R. notation could lead to serious criminal liability.

Minister for Health, the Honourable Peter Collins M.P. who referred the matter to the Crown Solicitor for legal advice. The advice received from the Crown Solicitor was to the effect that where life-saving treatment is withheld or withdrawn from a patient, serious issues of criminal liability arise on the part of any health service and individuals involved in the care and treatment of patients.¹⁶⁵ This advice prompted calls for the introduction of legislation in New South Wales that would provide protection to medical practitioners from legal liability for the withholding or withdrawing of medical treatment. In 1990, a discussion paper was prepared and circulated by the New South Wales Government, in which a proposal was put forward for the introduction of legislation based upon the South Australian *Natural Death Act* 1983.¹⁶⁶ The issue of active voluntary euthanasia was quite specifically excluded from consideration in the discussion paper.¹⁶⁷

The proposed legislation attracted criticism on the grounds that it did not adequately address the very problem that it attempted to solve, namely the legal liability of medical practitioners in circumstances where treatment is withheld or withdrawn.¹⁶⁸ As some critics pointed out, if legislation in the form proposed were introduced in New South Wales, doctors would only have the benefit of statutory protection in circumstances where the patient had executed an advance directive indicating that artificial life-support be withheld or withdrawn in the event of terminal illness, and it would not cover the majority of situations in ordinary medical practice.¹⁶⁹ Thus, it was argued, if there is a real and justifiable concern about the legal liability of doctors, more comprehensive legislation ought to be introduced.¹⁷⁰ The proposal mooted in the New South Wales Health Department discussion paper has also been criticised on the grounds that it does not give sufficient attention to patients' rights and the need to protect the right of all patients to refuse medical treatment.¹⁷¹ Indeed, a striking feature of the

¹⁶⁵ A copy of the Crown Solicitor's advice is included in the New South Wales Health Department, Discussion Paper *Proposed Legislation to Give Legal Effect to Directions Against Artificial Prolongation of the Dying Process* (1990) Appendix. In the opinion of the Crown Solicitor, even the consent of a patient to the withholding of medical treatment would not be a good defence. For a contrary view, see chapter II, 70-81.

¹⁶⁶ New South Wales Health Department, Discussion Paper, *Proposed Legislation to Give Legal Effect to Directions Against Artificial Prolongation of the Dying Process* (1990).

¹⁶⁷ *Id.* 1, 2.

¹⁶⁸ For example, the *Sydney Sunday Telegraph* 16 June 1991 and private correspondence with a number of doctors in New South Wales who had spoken out against the legislation.

¹⁶⁹ *Ibid.* It should be noted, however, that the South Australian legislation on which the New South Wales proposal was based, is in fact broader than the New South Wales proposal, in that the immunity conferred upon doctors with regard to the non-application or withdrawal of artificial life-support measures from a person suffering from a terminal illness applies regardless of whether or not the patient had executed a living will; compare s. 6(1) of the *Natural Death Act* 1983 (S.A.) and clause 5 of the legislation which was proposed for New South Wales.

¹⁷⁰ See A.M.A., N.S.W. Branch Council Resolution, 29 Jan. (1991) where the Council resolved as follows:
i) The N.S.W. Branch Council believes that there is a need for legislation to protect medical practitioners who do not revive terminally ill patients.
ii) That the Government enact an amendment to the *Medical Practitioners Act*. Such an amendment should be along the lines that, where a medical practitioner, in good faith, and in accordance with normal medical practice, withholds or withdraws treatment from a person in circumstances where death is imminent, in spite of the proposed treatment and where the treatment will secure only a burdensome prolongation of life, such medical practitioner will not be guilty of professional misconduct or negligence.

However, notwithstanding the threat of legal liability, some doctors in New South Wales believe that it is a mistake to introduce any legislation in this area; e.g. J. Graham, (letter) (1991) 337 *Lancet* 370-371.

¹⁷¹ See, for example, the N.S.W. Voluntary Euthanasia Society submission to the Legal Service Branch of the N.S.W. Department of Health on the Discussion Paper, 18 Jan. (1991).

developments in New South Wales is that they appear to have come about almost entirely as a result of concern about the potential legal liability of health care professionals rather than a general concern to enhance the rights of individual patients with regard to their medical treatment as has been the case in most other jurisdictions.¹⁷² As a result, there have been calls in New South Wales for legislation based on the Victorian model,¹⁷³ or alternatively, a combination of the South Australian and Victorian legislation.¹⁷⁴ However, even the broader Victorian legislation does not comprehensively cover the legal position of doctors, so if this is in fact the principal objective for legislation in New South Wales, a new legislative model will have to be developed.

As a result of the perceived drawbacks in the legislation proposed for New South Wales, the New South Wales branch of the A.M.A. made its concerns known to the Minister and a forum was organised in conjunction with the New South Wales Department of Health in June 1991 to deal with the matter. This forum highlighted concerns about the form of the government's legislative proposal and as a result, plans to introduce legislation in New South Wales based upon the South Australian model have been shelved.¹⁷⁵ In order to address some of the uncertainties and concerns which had been raised in this area, the New South Wales Department of Health is in the process of developing clinical guidelines for the treatment of dying patients. Consideration is also being given to the introduction of some mechanism to allow for the appointment of an agent or guardian to make decisions on behalf of a formerly competent patient.¹⁷⁶

Proposals for Active Voluntary Euthanasia

Although the subject of euthanasia has been avoided by most political parties, forthright support for active voluntary euthanasia has come from the A.C.T. branch of the Australian Labor Party. At its annual branch conference held in June 1991, the A.C.T. branch adopted the concept of active voluntary euthanasia as party policy. The policy states that under certain conditions:

If a patient who has been counselled consistently requests assistance to die and two doctors are of the view that there is little or no prospect of substantial improvement of the patient's condition, then it should not be an offence for a doctor to assist the patient to die.¹⁷⁷

¹⁷² Clearly, however, concern about the potential legal liability of health care professionals can in turn impact on the welfare of patients if doctors are reluctant to withhold or withdraw medical treatment because they fear prosecution, even though such withdrawing or withholding would be regarded as humane and appropriate medical practice.

¹⁷³ For some time, the Opposition health spokesman, Dr Andrew Refshauge M.P., has been pressing for legislation to allow the terminally ill to die with dignity and has in fact been considering introducing a Private Member's Bill based upon the Victorian legislation; Press Release, 14 Aug. 1990.

¹⁷⁴ N.S.W. Voluntary Euthanasia Society submission to the Legal Service Branch of the N.S.W. Department of Health on the Discussion Paper, 18 Jan. (1991).

¹⁷⁵ *The Sydney Morning Herald* 26 July 1991.

¹⁷⁶ Verbal communication with Caroline Marsh, Legal Branch, N.S.W. Health Department, 6 May 1992.

¹⁷⁷ *The Canberra Times*, 16 June 1991.

The Honourable Terry Connolly M.L.A., the A.C.T. Attorney-General and spokesman for the party's legal policy committee, is reported to have said that the A.C.T. Labor government will move to implement the policy but not immediately and not without community consultation. He expressed the view that it would be appropriate to set up an Assembly Committee to examine the matter and to consult with the community.¹⁷⁸

The adoption of this policy by the A.C.T. branch of the Australian Labor Party represents quite a milestone in the history of active voluntary euthanasia in Australia, being the first time that a political party has officially endorsed its legalisation. There has already been some opposition to the proposal;¹⁷⁹ however, this is to be expected given the controversial nature of the subject. It remains to be seen whether the A.C.T. branch will persevere with this policy and whether it will be successful in securing its implementation.

Evaluation of Australian Reform Developments

Apart from a number of inquiries which have touched on the issue of mercy killing from a criminal law perspective, and which are only of incidental relevance to the subject of active voluntary euthanasia, governmental and legislative reform developments in Australia have generally been limited to the area of passive euthanasia.¹⁸⁰ The thrust of these reforms has been to endorse the patient's common law right to refuse treatment resulting in the introduction of legislation in some Australian jurisdictions, enabling individuals to make advance declarations regarding medical treatment or appoint an agent to make treatment decisions on their behalf in the event that they lose decision-making capacity. In addition to clarifying the common law position, which has at best been murky in circumstances where a formerly competent patient loses decision-making capacity, these developments have also played an important educative role in drawing attention to patients' rights and raising the level of public debate and consciousness about these issues.

In comparison with the United Kingdom and the United States, where legislative efforts have frequently been made to introduce legislation to permit active voluntary euthanasia,¹⁸¹ there has, to date, been very little serious legislative activity in Australia aimed at introducing such legislation. Whilst the voluntary euthanasia societies in Australia have as their long term objective the legalisation of active voluntary euthanasia, they have generally steered a more conservative and

¹⁷⁸ *Ibid.*

¹⁷⁹ *The Canberra Times*, 17 June 1991.

¹⁸⁰ Note also the position in New Zealand as a result of the enactment of the *Bill of Rights Act* 1990, s. 11 of which provides that everyone has the right to refuse to undergo medical treatment. The Act is, however, limited in operation by virtue of s. 3 which states that the Act only applies to acts done by the legislative, executive, or judicial branches of the government of New Zealand (s. 3(a)); or by any person or body in the performance of any public function, power or duty conferred or imposed on that person or body pursuant to law (s. 3(b)). It has been suggested that the spirit of the Act will have a wider operation and that other legislative enactments (e.g. the New Zealand *Crimes Act* 1961 must now be interpreted in the light of this Act; see H. Souness, 'Dying Voices' (unpublished Honours thesis, Law Library, Victoria University of Wellington 1991) 20-21.

¹⁸¹ See below, 318-321 and 324-326, 339-345.

pragmatic course towards reform than their counterparts in the United Kingdom or the United States, presently concentrating their efforts on improving understanding and acceptance of active voluntary euthanasia. It is only in fairly recent times that work has been underway towards the preparation of draft legislation aimed at decriminalising aiding and abetting suicide and towards the legalisation of active voluntary euthanasia.¹⁸²

Brief consideration will now be given to some of the more important reform developments in the other common law jurisdictions under consideration, including legislative efforts to introduce laws permitting active voluntary euthanasia and government initiated law reform commission and parliamentary inquiries touching on the issue.

United Kingdom

The United Kingdom has a long history of reform efforts to introduce legislation for the legalisation of active voluntary euthanasia due to the early development of the voluntary euthanasia movement in that country. The Voluntary Euthanasia Society in London was the first such society to be established in the common law world and has, since its inception in 1935, actively pursued the introduction of active voluntary euthanasia legislation. Quite a number of Bills have been prepared and introduced into parliament but to date these reform efforts have been unsuccessful. Apart from these legislative activities which have been largely initiated by the Voluntary Euthanasia Society, there have also been a number of governmental inquiries in the United Kingdom which have considered the issue of mercy killing as well as recent reform initiatives undertaken by the Centre for Law and Medical Ethics and the Institute of Medical Ethics.

Legislative Developments

In 1936, a Bill, known as the *Voluntary Euthanasia (Legalisation) Bill* which was promoted by the newly established British Voluntary Euthanasia Society, was introduced into the House of Lords by Lord Ponsonby. Under this Bill, in order to be eligible for active voluntary euthanasia, a patient had to be over 21 years of age, suffering from an incurable and fatal illness, and was required to sign a form in the presence of two witnesses asking to be put to death. Before a patient's request for active euthanasia would be approved, a complicated legal procedure would have to be complied with, including investigation of the case by a 'euthanasia referee' and a hearing before a special court.¹⁸³ If the necessary conditions were satisfied, a license would be issued permitting active voluntary

¹⁸² See chapter VI, 241-242.

¹⁸³ The Euthanasia Society, *A Plan for Voluntary Euthanasia* (Revised ed., 1962) 10; J. Gould and Lord Craigmyle, (eds.) *Your Death Warrant?* (1971) 29-30; R. Russel, *Freedom to Die* (Revised ed., 1977) 68-70.

euthanasia to be administered by a doctor in the presence of an official witness.¹⁸⁴ The Bill was given a first reading, but was rejected by the House of Lords on the second reading by a vote of 35 to 14.¹⁸⁵ It was subsequently acknowledged by the Voluntary Euthanasia Society that the cumbersome safeguards included in the Bill had largely been responsible for its defeat, with opponents of the legislation having objected that it would bring too much formality into the sickroom.¹⁸⁶

Under the guidance of Professor Glanville Williams, a notable supporter of active voluntary euthanasia,¹⁸⁷ new legislation was developed during the 1960s for the legalisation of active voluntary euthanasia which provided for a much simplified procedure with a minimum of formality.¹⁸⁸ The revised Bill authorised a doctor to administer active euthanasia to a consenting patient thought on reasonable grounds to be suffering from an 'irremediable condition',¹⁸⁹ and who had, not less than 30 days previously, signed a declaration requesting the administration of active euthanasia. In addition to streamlining the procedure for the administration of active voluntary euthanasia, the Bill contained a number of other significant changes from the earlier legislation. One such change was the substitution of the requirement of an 'irremediable' condition for the requirement of a 'fatal' condition which had been contained in the earlier legislation, thereby considerably extending the range of cases to which active voluntary euthanasia would become applicable. Another important new feature of the proposed legislation was that it allowed for an advance declaration, enabling persons to request in advance the administration of active euthanasia in the event of their suffering from an irremediable condition at some future date.¹⁹⁰ The Bill also sought to provide protection to doctors and nurses, who in good faith, administered active voluntary euthanasia in accordance with the legislation.¹⁹¹ In 1969 Lord Raglan introduced into the House of Lords the *Voluntary Euthanasia Bill* modelled along these lines (with minor modifications). However, the Bill was rejected on the second reading by a vote of 61 to 40.¹⁹² Although the Bill was defeated, the vote in the House reflected a substantial increase in support since the 1936 Bill. Moreover, many of those who voted against the 1969 Bill indicated that they supported it in principle, but objected to some of the specific details of the legislation.¹⁹³

¹⁸⁴ T. Helme, 'The Voluntary Euthanasia (Legalisation) Bill (1936) Revisited' (1991) 17 *J. Med. Ethics* 25, 25.

¹⁸⁵ For detailed consideration of the parliamentary debates, see Gould and Craigmyle, 38-44.

¹⁸⁶ See G. Williams, *The Sanctity of Life and the Criminal Law* (1956) 298; Euthanasia Society, *A Plan for Voluntary Euthanasia*, 10.

¹⁸⁷ See, for example, *The Sanctity of Life and the Criminal Law*, 302 where he sets out his suggestions for reform; and 'Voluntary Euthanasia - The Next Step', an address delivered by Professor Williams on the occasion of the 1955 Annual General Meeting of the Euthanasia Society.

¹⁸⁸ The Euthanasia Society, *A Plan for Voluntary Euthanasia*.

¹⁸⁹ 'Irremediable condition' was defined in clause 1 of the Bill to mean 'a serious physical illness or impairment reasonably thought in the patient's case to be incurable and expected to cause him severe distress or render him incapable of rational existence.'

¹⁹⁰ See the Preamble of the Bill, as well as the substantive provisions. For discussion see Gould and Craigmyle, 30-37; H. Trowell, *The Unfinished Debate on Euthanasia* (1973) 17-18.

¹⁹¹ Clause 5. The 1936 Bill did, implicitly at least, create an immunity for doctors; see clause 1.

¹⁹² For reference to the parliamentary debates, see Gould and Craigmyle, 49-63. See also Note, 'Euthanasia Legislation' (1969) *M.J.A.* 987.

¹⁹³ Trowell, 18; Gould and Craigmyle, 49-63. For example, the Bill was criticised on the grounds of poor drafting, vague definition of terms and procedural difficulties.

The society's campaign for the legalisation of active voluntary euthanasia has continued to the present time. In the early 1980s a new draft Bill was prepared¹⁹⁴ and representations were made to members of parliament with the aim of gauging support for the proposed legislation.¹⁹⁵ In 1989, Mr Roland Boyes M.P. tabled an early day motion on behalf of the Voluntary Euthanasia Society, in the following terms:

That the House notes the results of the National Opinion Poll survey of May 1989 showing 75% in favour of the choice of medical help to die toward the end of life; notes that Holland has already made such a choice available to its citizens; and believes that it should also be available to the people of this country.¹⁹⁶

Quite a number of members of parliament indicated their support, by signing the early day motion.¹⁹⁷ Another early day motion in favour of active voluntary euthanasia was tabled in January 1990 and later that year, Mr Roland Boyes introduced a *Voluntary Euthanasia Bill* into the House of Commons under the 'ten minute rule'.¹⁹⁸ The Bill was, however, defeated by 101 votes to 35.¹⁹⁹

The society is presently campaigning to have a Private Member's Bill introduced into the parliament.²⁰⁰ This is dependent on persuading one of the society's M.P. supporters to agree to introduce such legislation, and then for that member to be drawn in the ballot in the House of Commons allowing that member the opportunity of introducing a Private Member's Bill.

Hopes for securing the passage of legislation have increased since the establishment in 1991 of an all-party parliamentary group for voluntary euthanasia on the initiative of Lady Nicol.²⁰¹ The group is chaired by the medical peer, Lord Winstanley, the Liberal Democrat spokesman on health.²⁰² The parliamentary group claims the support of 150 M.P.s and peers. Supporters of the group are drawn from both houses and the main political parties. About 70 supporters attended the inaugural meeting which was held in July 1991. A steering committee has been formed and an exploratory Bill may follow. As a preliminary step, the group, working in conjunction with the voluntary euthanasia society, is promoting draft legislation providing for the legal recognition of advance directives.²⁰³

¹⁹⁴ *Voluntary Euthanasia Bill*, Provisional Draft 1983. A copy of this Bill is contained in A. Downing and B. Smoker, *Voluntary Euthanasia* (1986) 284-287.

¹⁹⁵ See chapter VI, n. 98.

¹⁹⁶ Note, 'MP Calls for Legalised Euthanasia' (1989) 37 *V.E.S. Newsletter* 1.

¹⁹⁷ *Ibid.*

¹⁹⁸ Note, 'Voluntary Euthanasia' (1990) 40 *V.E.S. Newsletter* 10-12. The ten minute rule provides an opportunity for a backbencher member of parliament to raise an issue. If a Bill is successful at this stage, it simply means that the person putting forward the Bill has the opportunity for the Bill to be printed. There is, however, no chance of it directly becoming legislation through the ten minute rule procedure.

¹⁹⁹ *Id.* 12.

²⁰⁰ *Ibid.*

²⁰¹ Note, 'All Party Parliamentary Group' (1991) 43 *V.E.S. Newsletter* 9.

²⁰² Note, 'Euthanasia: New Issue for Conscience' (1991) 303 *B.M.J.* 1422.

²⁰³ *Medical Treatment (Advance Directives) Bill* 1992.

There have been a number of government initiated and other official inquiries in the United Kingdom which have touched upon the issue of euthanasia. As in Australia, these have generally focussed on the question of family mercy killings as distinct from medically administered active voluntary euthanasia. The deliberations and conclusions of these inquiries are therefore only of limited relevance in determining the appropriateness of legalising active voluntary euthanasia administered by a doctor.

Royal Commission on Capital Punishment

The Gower Royal Commission on Capital Punishment (1949-1953) gave consideration to whether mercy killing should be taken out of the category of murder.²⁰⁴ It was noted by the commission, that notwithstanding the mandatory death sentence for murder existing at the time, mercy killing was one class of case in which it was established practice for the Home Office to recommend the commutation of the sentence of death. Although the commission was clearly sympathetic to the proposal to treat mercy killing cases as a special category, it reluctantly came to the conclusion that it could not exempt mercy killing from the law of murder and that such cases should continue to be dealt with by way of discretion to mitigate the sentence of death, such as that exercised by the Secretary of State through the prerogative of mercy.²⁰⁵ This decision was primarily based upon the practical difficulties in giving effect to such a proposal, particularly having regard to evidentiary difficulties if the offence of mercy killing were to be defined in terms of motive of the offender, and the problem of defining a category which would not be open to abuse.²⁰⁶

It must be noted, however, that the commission was dealing with the case of mercy killings occurring in the family context, and did not specifically consider the more limited question of legalising active voluntary euthanasia administered by a doctor. Since doctors are independent third parties, unlikely to have any vested interest in the death of a patient, the objections raised by the commission, regarding motive of the offender and risk of abuse, arguably do not apply to active voluntary euthanasia administered in the medical context.

Criminal Law Revision Committee

Although the mandatory death penalty was abolished in 1965, all cases of murder in the United Kingdom, including mercy killing cases, are subject to mandatory life imprisonment. In 1976, the Criminal Law Revision Committee in its *Working Paper on Offences Against the Person*²⁰⁷ tentatively suggested that a new offence of mercy killing should be created to cover cases of unlawful killing of incurable patients from motives of compassion but not necessarily at the patient's request or

²⁰⁴ *Royal Commission on Capital Punishment* (1953) Cmnd. Papers, 8932, paras. 177-180.

²⁰⁵ *Id.* para. 180.

²⁰⁶ *Id.* para. 179.

²⁰⁷ Criminal Law Revision Committee, *Working Paper on Offences Against the Person* (1976) paras. 79-87.

with the patient's consent.²⁰⁸ A maximum penalty of two years imprisonment was suggested as the appropriate penalty applying in such cases, leaving open to judges the possibility of passing a non-custodial sentence. The committee made it clear that it was not suggesting legalisation of mercy killing but was simply seeking to deal with a handful of tragic killings for which a mandatory life sentence was inappropriate. However, the committee's proposal for the creation of a mercy killing offence met with substantial opposition,²⁰⁹ and in its final report the committee unanimously decided to withdraw the proposal.²¹⁰

House of Lords Select Committee on Murder and Life Imprisonment

In 1989 a Select Committee of the House of Lords was established on murder and life imprisonment. Under the committee's terms of reference it was, *inter alia*, required to consider the scope and definition of the crime of murder. The Voluntary Euthanasia Society presented a submission to the Select Committee where it suggested the creation of a special defence for cases of mercy killing.²¹¹ However, after considering this proposal, the committee recommended that there be no change in the current law.²¹²

Apart from these criminal law inquiries which have considered the issue of mercy killing, there have been a number of other significant developments in the United Kingdom.

Living Will, Working Party Report

Under the auspices of Age Concern and the Centre for Medical Law and Ethics, a multi-disciplinary working party was set up to examine the medical, ethical and legal issues with regard to advance directives for health care. The report of the working party,²¹³ released in 1988, proceeds on the basis of maximising respect for the liberty of individuals and autonomous decision-making. Whilst the report concludes that some improvement to the status quo is required,²¹⁴ it is somewhat more cautious in prescribing the precise steps which should be taken.²¹⁵ With the aim of promoting debate on the issue, the report canvasses the range of options available and summarises the principal arguments for and against each option. The report goes on to recommend either the introduction of living wills on a non-statutory basis or alternatively, a combination of living wills and durable

²⁰⁸ The committee suggested that the offence would apply to a person who, from compassion, unlawfully kills another, where the accused with reasonable cause, believed that the victim was (1) permanently subject to great bodily pain or suffering or (2) permanently helpless from bodily and mental incapacity, or (3) subject to rapid and incurable bodily or mental degeneration.

²⁰⁹ Criminal Law Revision Committee, Fourteenth Report, *Offences Against the Person* (1980) Cmnd. 7844, para. 115.

²¹⁰ For criticism of the committee's decision to withdraw its proposal for the creation of an offence of mercy killing, see R. Leng, 'Mercy Killing and the CLRC' (1982) 132 *New L.J.* 76.

²¹¹ See the submission from the Voluntary Euthanasia Society to the Select Committee on Murder and Life Imprisonment (1989).

²¹² Note, 'Voluntary Euthanasia' (1990) 40 *V.E.S. Newsletter* 10, 11.

²¹³ Age Concern Institute of Gerontology and Centre of Medical Law and Ethics, Working Party Report, *Living Will* (1988).

²¹⁴ *Id.* 86.

²¹⁵ *Id.* 77.

powers of attorney on a statutory basis, but stresses the need for further public and political debate in this area before any final decision can be made.²¹⁶

Whilst this reform initiative deals with living wills and does not deal directly with the issue of active voluntary euthanasia, the report is significant for its strong recognition of the importance of respect for individual liberty and autonomy, and for its efforts to clarify and protect the rights of formerly competent patients. The report has received widespread support and commendation from those concerned with the issues it addresses. Public debate on these issues has been further stimulated by the recent efforts of the all party parliamentary group on euthanasia to introduce legislation giving legal recognition to advance directives.²¹⁷

Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death

An important development on the subject of active voluntary euthanasia has been the work of the Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death. In response to frequent calls for review, the Institute of Medical Ethics set up a multi-disciplinary working party to investigate and report on the ethics of prolonging life and assisting death. The individuals invited to serve on the working party were drawn from a number of disciplines, and were chosen with the intention of representing a broad spectrum of ethical viewpoints on the subject. In September 1990, the working party released a discussion paper, published in the *Lancet*,²¹⁸ in which it examined in what circumstances, if any, a doctor is ethically justified in assisting death.²¹⁹ After considering some of the commonly raised objections to assisting death, and the moral debate as to whether there is any difference between killing and letting die, the working party suggested that in circumstances where a patient is suffering from a terminal illness, where distressing symptoms cannot be relieved and the patient asks to have his or her life ended, the balance of the moral argument shifts towards asking why death should not be assisted; the greater the unrelieved pain and distress, the more ethical is a doctor's decision to assist death if the patient desires it. The majority of the working party concluded that:

A doctor, acting in good conscience, is ethically justified in assisting death if the need to relieve intense and unceasing pain or distress caused by an incurable illness greatly outweighs the benefit to the patient of further prolonging his life... Assistance of death, however is not justified until the doctor and the clinical team are sure that the patient's pain and distress cannot be relieved by any other means-pharmacological, surgical, psychological, or social.²²⁰

²¹⁶ *Id.* 77-85.

²¹⁷ See above, 320. For general discussion regarding the likelihood and desirability of introducing living will legislation in the United Kingdom, see D. Greaves, 'The Future Prospects For Living Wills' (1989) 15 *J.Med. Ethics* 179-182.

²¹⁸ Institute of Medical Ethics, Working Party on the Ethics of Prolonging Life and Assisting Death, 'Assisted Death' (1990) 336 *Lancet* 610.

²¹⁹ *Id.* 611. For the purposes of the discussion paper, 'assisting death' is used to refer to an act by a doctor with the deliberate intention of hastening the death of a patient with a terminal illness.

²²⁰ *Id.* 613.

The discussion paper of the working party, and in particular, its endorsement of assisted death in certain circumstances, is clearly a development of enormous significance. It represents an unequivocal rejection of the position of the B.M.A. working party in its 1988 report²²¹ and is likely to be the focus for ongoing debate in this area in the United Kingdom.²²²

United States

The United States also has a long history of reform efforts to introduce legislation for the legalisation of active voluntary euthanasia. The earliest Bill dates back to 1906 and since that time, particularly in the period between 1936 and the late 1950s, quite a number of voluntary euthanasia Bills have been prepared and introduced into various State legislatures, although they have invariably been unsuccessful. There has, however, been significant legislative activity in the United States with regard to passive euthanasia through the enactment of living will legislation in the majority of American States. Efforts are now again being made in a number of States for more far-reaching reforms encompassing a form of active voluntary euthanasia. The organisation Americans Against Human Suffering has been campaigning for the introduction of legislation permitting physician aid-in-dying in a number of States through the voter initiative mechanism. In a number of other States, which do not have this voter initiated referendum process, voluntary euthanasia legislation has been introduced as Private Members' Bills.

Apart from legislative developments, another significant development to have taken place in the United States in recent years was the President's Commission inquiry into decisions to forgo life-sustaining treatment.

Early Legislative Developments

The first voluntary euthanasia Bill to have been introduced in the United States, and for that matter, in any English speaking country in the world, was the Bill for the legalisation of active voluntary euthanasia for certain incurable sufferers introduced in the legislature of Ohio in 1906 as a Private Member's Bill.²²³ Under the proposed legislation, an adult of sound mind, who had been fatally hurt or was so ill that recovery was impossible, or who was suffering from extreme physical pain without hope of recovery, could express to his or her doctor the wish to die. Provided that three further doctors agreed that the case was hopeless, they were empowered to make arrangements to put the person out

²²¹ See chapter VI, 274-276.

²²² The work of the working party is continuing in this area. A further paper has been published (Institute of Medical Ethics, Working Party on the Ethics of Prolonging Life and Assisting Death, 'Withdrawal of Life-Support From Patients in a Persistent Vegetative State' (1991) 337 *Lancet* 96) and others are underway with regard to advance directives, clinical decisions about resuscitation and issues relating to neonates and young children; written communication with Dr K. Boyd, Research Director, Institute of Medical Ethics, October 1992.

²²³ Russel, 60-61.

of pain and suffering with as little discomfort as possible. Although proceeding to a first reading, the Bill was defeated by a vote of 79 to 23.²²⁴

In February 1937, a euthanasia Bill largely modelled on the 1936 British Bill was introduced into the Nebraska State legislature by Senator Comstock, and sponsored by Dr Philbrick, a retired doctor.²²⁵ The Nebraska Bill differed from the British Bill in two important respects: first, by allowing an application to be made on behalf of a minor or incompetent adult, who was suffering from an incurable or fatal disease; and second, by providing that active euthanasia could be performed even where the illness was not terminal.²²⁶ The Bill was referred to a committee and was postponed indefinitely, having never been submitted to a vote.²²⁷ There was also an unsuccessful attempt to introduce a similar Bill into the New York legislature but without the provisions with regard to minors and incompetent adults.²²⁸

By 1938, the Euthanasia Society of America was established and for many years was the driving force behind efforts to secure legislative reform with regard to active voluntary euthanasia. In response to growing indications of community support for active voluntary euthanasia by the mid 1940s, the Euthanasia Society of America began a campaign in New York to secure the legalisation of active voluntary euthanasia. In 1947 a euthanasia Bill was presented to the New York Legislature. This Bill, also based on the 1936 British Bill, provided that any person of sound mind, over 21 years of age and suffering from severe physical pain caused by disease for which there is no known remedy, could, by written petition, apply to have active euthanasia administered. As under the 1936 British Bill, a complicated legal procedure was involved, pursuant to which a commission was to be appointed by the court to investigate the patient's request. Subject to a favourable report from the commission, the court would grant the patient's petition permitting the administration of active euthanasia.²²⁹ However, the Bill met with opposition and by the end of 1949 had still not been introduced into the New York legislature.²³⁰ In 1952, a further attempt was made to get the New York State legislature to consider this legislation²³¹ but the Bill once again failed to reach the legislature notwithstanding evidence of wide support for the proposal from doctors, the clergy and the community.²³²

In the decades which followed, further unsuccessful attempts were made to pass active voluntary euthanasia legislation in a number of American jurisdictions. In 1950, a Bill was proposed for the

²²⁴ *Id.* 61.

²²⁵ *Id.* 71-72.

²²⁶ See R. Kaplan, 'Euthanasia Legislation: A Survey and a Model Act' (1976) 2 *Am.J. Law & Med.* 41, 53; W. Baugham, J. Bruha and F. Gould, 'Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations' (1973) 48 *Notre Dame Law.* 1202, 1253; E. Gurney, 'Is there a Right to Die? - A Study of the Law of Euthanasia' (1972) 3 *Cumberland-Samford L.Rev.* 236, 252.

²²⁷ Russel, 72; Gurney, 252; D. Humphry and A. Wickett, *The Right to Die* (1986) 15-16.

²²⁸ Williams, *Sanctity of Life and the Criminal Law*, 296; Baugham, Bruha and Gould 1203, 1253.

²²⁹ Russel, 95-96; J. Fletcher, *Morals and Medicine* (1979) 187; A. Levishon, 'Voluntary Mercy Deaths' (1961) 8 *J. Forensic Med.* 57, 70; T. Martin, 'Euthanasia and Modern Morality' (1949-52) 9 *Jurist* 437.

²³⁰ Russel, 96-97.

²³¹ Humphry and Wickett, 51; Russel, 132-133.

²³² Russel, 133.

State of Connecticut and was introduced with some modifications, into the Connecticut General Assembly in 1959 at the initiative of the State chapter of the Euthanasia Society.²³³ This Bill, which was, essentially, couched in the same terms as the New York Bill,²³⁴ was also defeated. In the light of these set backs, the Euthanasia Society of America decided that further legislative efforts would be fruitless and resolved to shift its campaign for reform towards educational activities.²³⁵ The Bills which were subsequently introduced into the legislatures of a number of American States were initiated independently of the activities of the Euthanasia Society and were substantially similar to the 1969 *Voluntary Euthanasia Bill* proposed in the United Kingdom. In 1969, the Health and Welfare Committee of the Idaho House of Representatives introduced a voluntary euthanasia Bill to legalise the painless inducement of death at the request of a patient suffering from an irremediable condition.²³⁶ Notwithstanding quite detailed safeguards built into the legislation, it failed to pass. The next attempt at legislative reform was in Oregon in 1973 when a voluntary euthanasia Bill was introduced by a group of Senators into the Oregon legislature.²³⁷ However, this Bill was tabled after a single hearing.²³⁸ In the same year a Bill to legalise active voluntary euthanasia was introduced into the Montana State legislature²³⁹ but this Bill was also defeated.²⁴⁰

Living Will Legislation

By the late 1960s and early 1970s legislative efforts in the United States were increasingly concerned with the protection of patients' 'right to die with dignity' and by 1975, living will legislation had been introduced in some 15 States.²⁴¹ This shift in legislative attention from active to passive euthanasia must be understood against a growing concern in the community with respect of the excesses of modern medical technology as well as concern amongst health care professionals regarding their potential legal liability for withholding or withdrawing medical treatment. Moreover, since the late 1960s, the voluntary euthanasia societies in the United States had been paving the way for reform in this area.²⁴²

The first State to introduce living will legislation was California, with the enactment of the *Natural Death Act* in 1976. Introduced by Assembly man Barry Keene, the Californian *Natural Death Act* 1976 provides a mechanism enabling competent adults to execute a written directive or living will to the effect that they do not wish to be provided with artificial means of prolonging life in the event

²³³ Russel 133-135.

²³⁴ One difference was that the Connecticut Bill provided for an advance declaration of the patient's request; Russel, 134.

²³⁵ Russel, 132, 180.

²³⁶ *Voluntary Euthanasia Bill* 1969; see Russel 192; Humphry and Wickett, 95-96.

²³⁷ *Voluntary Euthanasia Bill* 1973.

²³⁸ Russel, 193.

²³⁹ *Voluntary Euthanasia Bill* 1973.

²⁴⁰ Russel 194; Humphry and Wickett, 107.

²⁴¹ Russel 188; Humphry and Wickett, 108.

²⁴² See chapter VI, 247-250.

that they have a terminal illness and are no longer able to express their wishes about their medical care.²⁴³ This legislation was premised on the fundamental right of patients to control the decisions relating to their own medical care, in circumstances where they are no longer competent to make their wishes known, including the decision to have life-sustaining procedures withheld or withdrawn in the event of a terminal condition. The Californian *Natural Death Act* 1976 was, however, very much the product of political compromise: opposition from religious and pro-life groups forced significant amendments to the original Bill, resulting in substantial limitations on the scope and operation of the legislation.²⁴⁴

Since the introduction of the *Natural Death Act* in California in 1976, the majority of American States have passed similar legislation.²⁴⁵ The pace of reform has been somewhat uneven, however, with an acceleration of legislative activity in the years 1985 and 1986, exceeding any other period in the history of living will legislation.²⁴⁶ In quite a number of jurisdictions, significant amendments have been made to the legislation, and in some instances the original Act has been entirely replaced by new legislation.²⁴⁷ As a result of the general autonomy of State legislatures and the piecemeal implementation of living will legislation in the United States, considerable diversity exists in the legislative provision that has been made in the various jurisdictions, and this is reflected in the variety of titles under which these Acts have been introduced.²⁴⁸

Notwithstanding the diversity of the existing legislation certain features common to most jurisdictions can be identified. Essentially, the object of such legislation is to give legal recognition to living wills in circumstances where the patient no longer has decision-making capacity. In furtherance of this objective, the statutes establish a procedure enabling an adult who has decision-making capacity to execute a directive that medical treatment be withheld or withdrawn in the event that he or she becomes terminally ill.²⁴⁹ Thus, the statutes relate only to the withholding or withdrawing of treatment or what is in effect passive euthanasia and the only reference to active euthanasia in some of the statutes is for the purpose of specifically excluding it from the operation of

²⁴³ For detailed analysis of the Californian *Natural Death Act*, see, for example, E. Flannery, 'Statutory Recognition of the Right to Die: The California Natural Death Act' (1977) 57 *B.U.L.Rev.* 148; W. Winslade, 'Thoughts on Technology and Death: An Appraisal of California's Natural Death Act' (1976-77) 76 *De Paul L.Rev.* 717.

²⁴⁴ M. Lerner, 'State Natural Death Acts: Illusory Protection of Individuals' Life-Sustaining Treatment Decisions' (1992) 29 *Harv.J. on Legis.* 175, 187. For further discussion of the influence of pro-life forces on living will legislation in the United States, see below, 331.

²⁴⁵ For reference to living will legislation in the United States see Choice in Dying, 'Right-to Die Case and Statutory Citations State-by-State Listing' Nov. 1991. See also G. Gelfand, 'Living Will Statutes: The First Decade' (1987) *Wis.L.Rev.* 737, 739 where he lists in chronological order the 38 States and the District of Columbia which had, as of 1987, enacted such legislation.

²⁴⁶ Society for the Right to Die, *Handbook of Living Wills* (1987) 5.

²⁴⁷ For coverage of legislative developments, see Choice in Dying, 'Right-to Die Case and Statutory Citations State-by-State Listing' Nov. 1991.

²⁴⁸ For example, California *Natural Death Act* 1976; Alaska *Rights of the Terminally Ill Act* 1986; Arizona *Medical Treatment Decision Act* 1985; Delaware *Death with Dignity Act* 1982; Florida *Life-Prolonging Procedure Act* 1981; Georgia *Living Wills Act* 1984; Louisiana *Life-Sustaining Procedures Act* 1984; Missouri *Life Support Declarations Act* 1985; New Mexico *Right to Die Act* 1977; Oregon *Rights with Respect to Terminal Illness Act* 1977.

²⁴⁹ Some statutes are broader in scope, allowing a declaration to be made on behalf of an incompetent adult or a minor patient; see D. King *et al.*, 'Where Death Begins While Life Continues' (1990) 31 *S.Tex.L.Rev.* 145, 173.

the legislation.²⁵⁰ Further, the patient's directive only comes into operation after the patient loses decision-making capacity: whilst the patient still has the capacity to make decisions regarding his or her health care, the doctor must ascertain the patient's current wishes with regard to medical treatment.

All of the statutes require certain formalities for the execution of living wills although the details of the formalities vary significantly as between jurisdictions.²⁵¹ In most States, the threshold standard in order for the patient's directive to be operative depends on the existence of a 'terminal illness,' however, statutes differ in their definition of this requirement.²⁵² For example, the statutes in quite a number of jurisdictions specify that the patient's condition must be such that death will occur shortly *whether or not* life-supporting treatments are administered.²⁵³ In some States, the statutes also refer to the timing of death for the purposes of defining a terminally ill patient, for example, by requiring that death must be 'imminent' or that it will occur within a 'short time'.²⁵⁴

All living will legislation contains some limitations on the types of treatments which may be withheld or withdrawn pursuant to the advance direction of a patient. For example, some statutes specifically provide that a directive only applies in respect of 'life-sustaining procedures';²⁵⁵ others refer to 'artificial' or 'mechanical' treatments or 'extraordinary measures';²⁵⁶ and the majority of living will statutes specifically exempt nutrition, hydration, comfort care and treatment for the alleviation of pain from the range of treatments that may be withheld or withdrawn.²⁵⁷

An important feature of all living will legislation is that it confers immunity upon health professionals from civil and criminal liability if they withhold or withdraw life-sustaining procedures in accordance with the patient's directive.²⁵⁸ The majority of statutes do not impose upon doctors a duty to comply with the patient's directive. Where a doctor is unwilling to comply with a patient's directive, most living will statutes require the doctor to transfer the patient to another doctor.²⁵⁹ However, only a few statutes actually contain penalties for the doctor's failure to comply with the patient's directive or to take steps to ensure that another doctor does so, and under most of those Acts, the doctor's failure to give effect to a patient's directive is simply treated as unprofessional conduct and is not an offence under the legislation.²⁶⁰

²⁵⁰ Gelfand, 748.

²⁵¹ Under most living will statutes, the declaration must be in writing, it must be witnessed, and the declarant must be a competent adult at the time of signing. Under many of the living will Acts, the directive must be in accordance with a prescribed statutory form. See generally Gelfand, 755-765.

²⁵² Gelfand, 740-747.

²⁵³ *Id.* 741.

²⁵⁴ *Id.* 743-744.

²⁵⁵ For example, Californian *Natural Death Act* 1976.

²⁵⁶ Gelfand, 752-753.

²⁵⁷ *Id.* 750-751.

²⁵⁸ *Id.* 771-773.

²⁵⁹ *Id.* 768-768.

²⁶⁰ *Id.* 777.

Under the majority of statutes, a directive will remain in force indefinitely unless specifically revoked.²⁶¹ All living will statutes provide procedures for the revocation of a directive, with the majority of statutes adopting fairly liberal revocation provisions. The statutes generally provide for revocation, either formally by the execution of an instrument expressing an intent to revoke, or by a physical act or verbal expression of the declarant or individual acting on his or her behalf, communicated to the doctor. Many of the statutes permit revocation of a directive regardless of the mental state or competency of the declarant, in order to ensure that under no circumstances, a directive is carried out against the present wishes of the patient.

Specified Limits on the Scope of Living Will Statutes

The living will legislation in most States contain penalties with regard to causing a person's life to be terminated against his or her will²⁶² and causing a person to be kept alive against his or her will by, for example, forging a revocation or destroying a declaration.²⁶³

The legislation in some States provides that actions in accordance with the Act do not constitute suicide or aided suicide and quite a few statutes specifically state that nothing in the statute condones, authorises or approves mercy killing or euthanasia.²⁶⁴

Another limitation on the operation of living will legislation in many jurisdictions arises in circumstances where the declarant is pregnant at the time when she is diagnosed as terminally ill. In most States, the statute provides that a directive shall have no force or effect during pregnancy. However, a minority of States have adopted a more liberal course, by restricting the operation of the living will only in circumstances where the fetus could develop to the point of live birth.²⁶⁵

In order to protect the position of patients who have not executed a living will, most living will statutes provide that the failure of a patient to execute a living will creates no presumption as to the wishes of the patient regarding the use, withholding or withdrawing of life-sustaining medical treatment.²⁶⁶ A further provision contained in most living will statutes is that the rights created under the legislation do not displace or effect any judicially created rights and procedures. Thus, the common law right of patients to refuse treatment is specifically preserved. As a result, interesting questions arise as to the legal status of an advance directive which falls outside the terms of living will legislation. The interrelationship between, on the one hand, a patient's common law and constitutional right to refuse treatment, and living will legislation on the other, was to some extent addressed by the United States Supreme Court in the case of *Cruzan v Director, Missouri Department*

²⁶¹ Gelfand, 765.

²⁶² *Id.* 775.

²⁶³ *Id.* 776-7. In a number of States, additional crimes and penalties have been created, for example, to cover improper attempts to cause death or keep persons alive which do not succeed, or coercing a patient to sign a declaration.

²⁶⁴ *Id.* 785-86.

²⁶⁵ *Id.* 778-780.

²⁶⁶ *Id.* 783-787.

of Health.²⁶⁷ One of the conclusions which can be drawn from that decision is that the patient's right to refuse medical treatment may be exercised through a living will or other advance directive whether or not the State has enacted legislation permitting the use of such instruments. Moreover, provided the patient's directions in a living will or other advance directive clearly evidence the patient's wishes regarding the withdrawal of treatment, those directions will be valid, notwithstanding that living will legislation purports to limit the directions that a patient may give, for example, by excluding artificial nutrition and hydration, or by requiring that a patient be in a terminal condition.²⁶⁸

Uniform Rights of the Terminally Ill Act

Notwithstanding certain features common to most living will Acts, as noted earlier, considerable diversity exists in the provision which has been made in the various jurisdictions.²⁶⁹ In response to growing concern regarding the lack of uniformity of living will legislation in the United States, in 1983 the conference of commissioners on uniform State laws commenced work on uniform living will legislation. The object of this initiative was to develop an Act which is simple and effective in its operation and which, through uniformity of scope and procedure, would ensure the effectiveness of a declaration in States other than the State in which it was executed.²⁷⁰ The end product of this work, the *Uniform Rights of the Terminally Ill Act*, was approved and recommended for enactment in 1985.²⁷¹ The Act has drawn upon existing legislation in order to avoid further complexity and to permit its effective operation in the light of prior enactments. The Act's basic structure and substance are therefore similar to that found in most existing legislation. Where necessary, departures have been made from the existing statutes in an attempt to simplify procedures, improve drafting and clarify language.²⁷² However, contrary to the hopes of the Conference of Commissioners, the response to the Act has not been overwhelming. A number of States which have introduced living will legislation, or amended existing legislation since the promulgation of the *Uniform Rights of the Terminally Ill Act* have substantially adopted the Act.²⁷³ It has been suggested that the many legislatures which already have living will legislation are unlikely to see much advantage in amending their legislation to bring it into conformity with the model Act.²⁷⁴ The remaining States which have not enacted living will legislation are generally those where the opposition to such legislation has been the greatest, so in order to be adopted, the *Uniform Rights of the Terminally Ill Act* will have to overcome the residual objection to such legislation in these States.²⁷⁵

²⁶⁷ 110 S. Ct. 2841 (1990). For analysis of this aspect of the decision, see D. Orentlicher, 'The Right to Die After Cruzan' (1990) 264 *J.A.M.A.* 2444, 2445.

²⁶⁸ Orentlicher, 2445; F. Rouse, 'Advance Directives: Where Are We Heading After *Cruzan*?' (1990) 18 *Law, Med. & Health Care* 353.

²⁶⁹ See above, 327.

²⁷⁰ *Uniform Rights of the Terminally Ill Act*, Prefatory Note.

²⁷¹ For a review of the history of this legislation, see M. Chapman, 'The Uniform Rights of the Terminally Ill Act: Too Little, Too Late?' (1989) 42 *Kansas L.Rev.* 319.

²⁷² *Uniform Rights of the Terminally Ill Act*, Prefatory Note.

²⁷³ See Chapman, 374-377; W. Leschensky, 'Constitutional Protection of the "Refusal-of-Treatment": *Cruzan v Director, Missouri Department of Health*, 110 S. Ct. 2841 (1990)' (1991) 14 *Harv.J.L. & Pub.Pol'y.* 248, 257.

²⁷⁴ Chapman, 394. For critical analysis of the legislation see T. Marzen, 'The Uniform Rights of the Terminally Ill Act: A Critical Analysis' (1986) 6 *Issues Law & Med.* 441.

²⁷⁵ Chapman, 394.

Critical Analysis of the Living Will Legislation in the United States

It must be acknowledged that the living will legislation introduced in the United States does address a very important need by providing a mechanism whereby instructions about health care decisions prepared whilst the patient has decision-making capacity remain in effect after the patient loses that capacity. Thus, in circumstances where the legislation applies, (and indications are that only a minority of patients in the United States have prepared a living will²⁷⁶) the patient's self-determination is upheld, the family is spared making difficult decisions about the withholding or withdrawing of treatment on behalf of the patient, and the need for costly litigation can generally be avoided.²⁷⁷ There are, however, a number problems with the current legislation.²⁷⁸

One of the major criticisms of the living will legislation in the United States is that it is excessively narrow in scope, resulting in many categories of patients being excluded from its operation.²⁷⁹ Indeed, it has been pointed out that the situation in the landmark case of Karen Quinlan, which did much to highlight the medical-legal problems associated with incompetent patients would not in fact be covered by the legislation.²⁸⁰ The limited operation of the legislation is a product of a combination of factors but is primarily attributable to the requirement of a 'terminal illness' before the legislation can take effect and the fact that only treatment in the nature of 'artificial life-support' can be refused.²⁸¹ The effect of these limitations is that the legislation will only be of assistance in a narrow range of cases and many categories of patients, arguably most in need of legislative assistance in having their wishes respected, are excluded from its operation.²⁸² Pressure from right to life groups and other interest groups led to the inclusion of this and other limitations²⁸³ which have arguably weakened the objectives of the legislation.

Living will legislation in the United States has also been criticised for the many ambiguities and uncertainties in the terminology and operation of the legislation.²⁸⁴ In some instances, there is no definition of key terms, or even where defined, the definitions do not necessarily clarify the situation.

²⁷⁶ See below, n. 316.

²⁷⁷ For recognition of some of the benefits of legally recognised advance directives, see K. Davidson *et al*, 'Physicians' Attitudes on Advance Directives' (1989) 262 *J.A.M.A.* 2415.

²⁷⁸ For criticism of the living will legislation see, for example, Lerner, 'State Natural Death Acts: Illusory Protection of Individuals' Life-Sustaining Treatment Decisions'.

²⁷⁹ Compare this view with that of commentators at the other end of the spectrum who argue that the legislation is too permissive; for discussion see J. Moskop, 'Advance Directives in Medicine: Choosing Among the Alternatives' in C. Hackler, R. Moseley and D. Vawter, (eds.) *Advance Directives in Medicine* (1989) 9, 11-12.

²⁸⁰ R. Veatch, 'Death and Dying: The Legislative Options' (1977) 7 *Hastings Center R.* 5, 6; L. Heintz, 'Legislative Hazard: Keeping Patients Living Against Their Wills' (1988) 14 *J.Med. Ethics* 82, 85.

²⁸¹ Heintz, 83-86; Gelfand, 740-747, 750-753.

²⁸² For example, most living will legislation would not apply to a formerly competent patient, now comatose whose condition is not terminal and where death is not imminent. See Heintz, 84-85; G. Annas and L. Glantz, 'The Right of Elderly Patients to Refuse Life-Sustaining Treatment' (1986) 64 *Milbank Q.* 95, 139-141; M. Lappe, 'Dying While Living: A Critique of Allowing-to-Die Legislation' (1978) 4 *J.Med. Ethics* 195, 198.

²⁸³ Humphry and Wickett, 290-291.

²⁸⁴ See Gelfand; W. Winslade, 'Thoughts on Technology and Death: An Appraisal of California's Natural Death Act' (1976-77) 16 *De Paul L.Rev.* 717, 727-730; E. Emanuel and L. Emanuel, 'Living Wills: Past, Present and Future' (1990) 1 *J. Clinical Ethics* 9, 10-12; Annas and Glantz, 141.

Furthermore, the legislation in some States is fraught with illogicalities and internal inconsistencies which threaten to undermine the object of the legislation. For example, under some living will statutes there is a requirement that the patient's death must be imminent, i.e. that the patient will die soon, whether or not life-sustaining procedures are used.²⁸⁵ This requirement, if taken literally, nullifies the whole purpose of living will statutes in enabling an individual to secure a 'natural' death.²⁸⁶ Another illustration of the contradictions inherent in the legislation is to be found in the general statutory statement in most living will legislation to the effect that nothing in the legislation condones or permits any type of euthanasia. However, the circumstances to which the legislation applies clearly come within the meaning of passive euthanasia as that phrase is now generally understood, and the Acts specifically provide that the legislation does not displace judicially created rights and procedures; rights and procedures which may in fact endorse the right of a patient to seek passive euthanasia.²⁸⁷

A very real concern which has been raised with regard to the operation of the living will legislation in the United States is that notwithstanding the good intentions of the framers of the legislation in seeking to promote patients' rights, the legislation may in fact be having the opposite effect of eroding the common law right to refuse treatment. As noted earlier, most of the Acts contain a specific provision to the effect that failure to execute a living will creates no presumption as to the wishes of the patient and further, that the statutorily created rights are not intended to impair or supersede any pre-existing common law rights.²⁸⁸ In this light, the legislation can be seen as simply offering an alternative mechanism for exercising patient rights, and thereby hopefully avoiding the need for litigation which the enforcement of common law rights in the United States has frequently entailed. Despite these specific provisions aimed at limiting the operation of the legislation, the concern has been raised that some doctors may, for fear of liability, be reluctant to withhold or withdraw artificial life-support in the event of terminal illness in the absence of a written directive under the legislation.²⁸⁹ The obvious concern is that if such legislation is viewed, albeit mistakenly, by health care providers as the exclusive means for making and implementing a decision to forgo treatment, some dying patients may be subject to treatment that is neither desired nor beneficial.²⁹⁰ Further, there is the additional danger that people will infer that a patient who has not executed a directive in accordance with the legislation, does not desire life-sustaining treatment to be ended under any circumstances, when in fact the failure to execute a directive may be because of ignorance of its existence, inattention to its significance, or for one of a number of other reasons.²⁹¹ It has been suggested that the statement in the legislation that it does not affect common law rights does not in

²⁸⁵ Gelfand, 740.

²⁸⁶ *Id.* 742.

²⁸⁷ *Id.* 785-786.

²⁸⁸ See above, 329.

²⁸⁹ For discussion, see for Veatch, 6; G. Alexander, 'Death by Directive' (1988) 28 *Santa Clara L.Rev.* 67, 95; D. Meyer, *Medico-Legal Implications of Death and Dying* (1981) 495-496.

²⁹⁰ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 144 (hereafter referred to as the President's Commission Report.)

²⁹¹ *Ibid.*

itself correct the difficulty.²⁹² Consequently, there is concern that in practice, the legislation may restrict, rather than promote, the patient's ability to have their wishes about life-sustaining treatment respected. And whilst it could well be argued that any tendency on the part of the medical profession to continue treatment in the absence of a directive may be an unwarranted response to the situation, it is nevertheless a matter of real concern if this is in fact occurring.

A further criticism which has been made of living will legislation in the United States is that most of the statutes confer protection upon doctors from liability without imposing any legal obligation to comply with the patient's directive.²⁹³ As one commentator has observed, to offer such a large degree of immunity in this sensitive area without imposing sanctions to protect the individual's right to have his or her wishes respected is both one-sided and unjustified.²⁹⁴

Another, more general objection which has been raised against living will legislation is that it attempts to address in advance medical problems not yet in existence. Since it is impossible for a person to contemplate every possible treatment choice and provide instructions in respect of that choice, directions under a living will to withhold life-sustaining treatment are inevitably made in abstract terms at a time when the person could not be fully informed about the circumstances and consequences of that decision.²⁹⁵ Further problems resulting from the advance nature of living wills is their inherent lack of specificity, which can in turn result in difficulties in interpretation.²⁹⁶

It should be noted that many of the foregoing criticisms and concerns apply equally to the *Uniform Rights of the Terminally Ill Act*, although this was largely as a result of limitations which were imposed on the drafting committee by the National Conference of Commissioners on Uniform State Laws.²⁹⁷ Consequently, the *Uniform Rights of the Terminally Ill Act* put forward as a 'model act', carries forward most of the problems with regard to the scope and operation of living will legislation.²⁹⁸ It must, however, be acknowledged that the Uniform Act does represent an improvement on existing living will legislation and has managed to overcome many of the ambiguities and internal inconsistencies in the earlier legislation.²⁹⁹

²⁹² *Ibid.*

²⁹³ R. Sherlock, 'For Everything There is a Season: The Right to Die in the United States' (1982) *B.Y.U.L.Rev.* 545, 605.

²⁹⁴ *Ibid.*

²⁹⁵ Law Reform Commission of Western Australia Report 12; Victorian Social Development Committee Report 50, 121; Manitoba Law Reform Commission, *Discussion Paper on Advance Directives and Durable Powers of Attorney for Health Care* (1990) 14.

²⁹⁶ Manitoba Law Reform Commission, *Discussion Paper on Advance Directives and Durable Powers of Attorney for Health Care*, 14, 16.

²⁹⁷ Annas and Glantz, 142-144.

²⁹⁸ *Ibid.*; Alexander, 96; Chapman, 384-394.

²⁹⁹ Amendments have been made to the original *Uniform Rights of the Terminally Ill Act*, including provision for a number of alternative options for the exercise of the right to refuse unwanted medical treatment apart from living wills; see F. Rouse, 'The Role of State Legislatures After Cruzan: What Can - and Should - State Legislatures Do?' (1991) 19 *Law. Med. & Health Care* 83, 86-87.

Notwithstanding the problems of living will legislation, it does, in some limited circumstances, operate to uphold the advance directions of a formerly competent patient. Moreover, one should not overlook the educative effect of the reform process which has been underway in the United States since the 1970s. The legislative approval of the patient's right to refuse treatment has had the practical effect of informing patients about their rights and reassuring doctors about the legality of their actions. Thus, perhaps the greatest value of such legislation is the impetus that it provides for discussions between patients, doctors and families about decisions to forgo life-sustaining treatment³⁰⁰ as well as the symbolic significance of enacting legislation which seeks to give effect to the patient's self-determination and the right to die a natural death.³⁰¹

Other Mechanisms for Preserving Patient Autonomy

Partly in an attempt to secure alternatives to living will legislation, a number of other mechanisms for preserving patient autonomy have been developed in the United States in recent years. These include provision for the appointment of a proxy decision-maker and the introduction of durable health care powers of attorney.³⁰²

Appointment of a Proxy Decision-Maker

One possible mechanism for persons to exercise autonomy in health care decisions is by appointing a family member, friend or other person as a 'proxy' or 'agent' to act on their behalf in the event of supervening incompetence.³⁰³ The main advantages of this mechanism is that the patient can select in advance a person who has knowledge of his or her treatment preferences and whom can be trusted to follow them. Moreover, unlike living will directions which are necessarily made in advance without full knowledge of the circumstances, appointment of a proxy ensures that the person who makes the decision is cognisant of the facts and circumstances and is in a position to make an informed decision. In a number of States, the living will legislation itself includes a provision for the appointment of a health care proxy.³⁰⁴ However, because the proxy's authority extends no further than the patient's authority, if the living will statute limits the kinds of directions that the patient may give, then the authority of a proxy appointed in accordance with the provisions a State's living will statute may be limited in the same way.³⁰⁵

³⁰⁰ Note also the President's Commission Report, 145; B. Towers, 'The Impact of the California Natural Death Act' (1978) 4 *J. Med. Ethics* 96, 98.

³⁰¹ Winslade, 736.

³⁰² Some States have passed medical surrogate laws which specify who can make a decision for an incompetent patient who left no advance directive; Note, 'States Move to Get Advance Directives' (1991) *Am. Med. News* (Nov.) 3.

³⁰³ Orentlicher, 2366. A proxy or agent can be created under a number of possible forms of statutory authority.

³⁰⁴ *Ibid.* referring to the legislation in Florida and Texas. See generally, the Society for the Right to Die, *Appointing A Proxy for Health Care Decisions* (1988) 5.

³⁰⁵ Orentlicher, 2366.

Durable Powers of Attorney

One form of proxy decision-making which has been developed in the United States has been the durable health care power of attorney. Legislation providing for general durable powers of attorney exist in all American States which, unlike ordinary powers of attorney, remain in effect in the event that the principal becomes legally incapacitated.³⁰⁶ Although this legislation is potentially broad enough to permit the agent to make medical treatment decisions for the principal, there has been some doubt as to whether general durable powers of attorney can be used for this purpose, particularly since this was not envisaged when this legislation was introduced.³⁰⁷ Moreover, concern has been expressed regarding the lack of appropriate procedural safeguards in the legislation if it were to be used for this purpose.³⁰⁸ In an attempt to overcome these uncertainties, further legislation has been introduced in quite a number of American jurisdictions specifically dealing with durable powers of attorney for health care and containing procedural safeguards for the protection of both the principal and the agent.³⁰⁹ Pursuant to this legislation the principal can give specific instructions or authority to the agent to act in all health care decisions for the principal.

Durable health care powers of attorney offer a number advantages over living wills.³¹⁰ To begin with, their operation is considerably wider, in that they are not restricted to cases of terminal illness where death is imminent and can generally be used to delegate authority for health care decisions in all cases of patient incompetence.³¹¹ Furthermore, the durable health care power of attorney is a much more flexible instrument, allowing the individual to determine the extent to which he or she will delegate decision-making to their appointed attorney. The delegation may be a broad one, permitting the agent to make any medical decision that the principal could have made if legally competent.³¹² Alternatively, the principal may wish to delegate only limited decision-making power and may even include in the delegation of power specific directions for treatment decisions.³¹³ The main advantage is that unlike a living will which is a fixed instrument, durable health care powers of attorney enable a patient to provide specific instructions in many circumstances, but at the same time can be

³⁰⁶ For a brief outline of the introduction of such legislation in the United States, see Annas and Glantz, 136-138.

³⁰⁷ Gelfand, 795. Note, however the President's Commission Report, 147 where it is suggested that durable power of attorney appointments as applied to health care decisions would be legally binding in view of the wide language of the statutes and the fact that nothing in the statutes explicitly precludes such a use. This view finds some support in the case of *In re Peter by Johanning* 529 A. 2d 419 (1987) in which the New Jersey Supreme Court held that an appointed agent may refuse life-sustaining treatment on the incapacitated principal's behalf, even where the State's durable power of attorney statute does not specifically address the issue of health care.

³⁰⁸ President's Commission Report, 147; G.P. Smith, 'All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?' (1989) 22 *U. Calif., Davis* 275, 332-333.

³⁰⁹ For reference to those jurisdictions which have such legislation see P. McCarrick, 'Living Wills and Durable Power of Attorney: Advance Directives Legislation and Issues' (1991) Scope Note 2, Kennedy Institute of Ethics, 4-5.

³¹⁰ There are also potential problems with durable powers of attorney and proxy appointments. It is not a solution in all cases because many people have no-one they could appoint as agent. Moreover, there is always the risk that the agent will make a decision contrary to what the desires of the principal would have been.

³¹¹ Orentlicher, 2366.

³¹² *Ibid.*

³¹³ Orentlicher, 2366. It is also possible to use a durable health care power of attorney in conjunction with living will legislation.

sufficiently broad to take account of unforeseeable contingencies by conferring upon the agent general decision-making authority in unanticipated circumstances.³¹⁴ Because the agent has clear authority to act on behalf of the principal, the use of durable powers of attorney would be likely to reduce the need or tendency to seek judicial intervention.³¹⁵

The Patient Self-Determination Act 1990

Although legislation now exists in most American States for some type of advance directive, surveys indicate that only a relatively small proportion of Americans have availed themselves of this legislation and executed an advance directive.³¹⁶ As a result, written advance directives still play only an occasional role in decisions to withhold or withdraw life-sustaining treatment from incapacitated patients and in the majority of cases decisions are made without the benefit of the patient's views.³¹⁷ Federal legislation has recently been introduced in the United States in an attempt to increase patients' involvement in decision-making about their medical treatment in the event that they become incompetent. The *Patient Self-Determination Act* was passed by Congress in October 1990 and is the first piece of federal legislation to address end of life decision-making in the United States. Under the legislation, which commenced operation in December 1991, all hospitals, hospices, nursing homes and other health care provision organisations must inform patients upon their admission about their right to refuse treatment and prepare 'advance directives' under applicable State law as well as provide information about the facility's own internal policies governing patients' rights. The Act defines an 'advance directive' as a written instruction, such as a living will or durable power of attorney for health care, recognised under State law ... and relating to the provision of such care when the individual is incapacitated.

More particularly, the Act requires that all health care facilities receiving federal funding (Medicare or Medicaid) to:

- maintain written policies on refusal of care and advance directives;
- give this written information to adults at the time of admission as hospital inpatients or as residents of a skilled nursing facility, before coming under the care of a home health agency or hospice, or upon enrolment in a health maintenance organisation;
- note in patient records whether an advance directive has been made;
- ensure compliance with advance directives consistent with State law;
- provide both staff and community education on advance directives.³¹⁸

³¹⁴ Orentlicher, 2366.

³¹⁵ *Ibid.*

³¹⁶ P. Greco *et al*, 'The Patient Self-Determination Act and the Future of Advance Directives' (1991) 115 *Annals Internal Med.* 639 where the authors note that only between 8% and 15% of American adults have prepared a living will.

³¹⁷ *Ibid.*

³¹⁸ Note, 'Searching for Death with Dignity' (1991) 65 *Bull.Med. Ethics* 3.

The Act has considerable bite in that failure to comply with the legislation will result in the loss of federal funding. It is anticipated that this legislation will dramatically increase awareness of patients' rights to control their medical treatment, including the right to prepare an advance directive. It will also help to ensure that existing directives are available to doctors at the time medical decisions are being made and that they are complied with.³¹⁹ The *Patient Self-Determination Act* thus represents an important initiative towards promotion and recognition of patients' rights to refuse treatment in the United States.

Government Inquiries

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research

As a natural outgrowth of the President's Commission's earlier work on informed consent,³²⁰ the definition of death and access to health care, though not actually part of its original mandate, a study was undertaken in 1981 with regard to decisions to forgo life-sustaining treatment.³²¹ Following two years of public hearings and discussions, the commission released its report, *Deciding to Forgo Life-Sustaining Treatment* in 1983. Although the commission was primarily concerned with the ethical, medical and legal issues with regard to the withholding or withdrawing of treatment,³²² the report does make some comments on the subject of active voluntary euthanasia. The commission was of the view that it would not be appropriate to legalise active voluntary euthanasia. Whilst recognising the artificiality of some of the distinctions which are made in the health care context, in particular, the distinction between acts and omissions,³²³ the commission came to the conclusion that the legal prohibition of active killing should be sustained.³²⁴ It expressed the view that:

Weakening the legal prohibition to allow a deliberate taking of life in extreme circumstances would risk allowing wholly unjustified taking of life in less extreme circumstances. Such a risk would be warranted only if there were substantial evidence of serious harms to be relieved by a weakened protection of life, which the Commission does not find to be the case.³²⁵

In examining the implications of its conclusion, the commission acknowledged that one serious consequence of maintaining the legal prohibition against killing of terminally ill patients could be the

³¹⁹ P. Greco *et al.*, 639. For analysis of the legislation, see Practicing the P.S.D.A. (1991) 21 *Hastings Center Report* (Special Supplement); E. McCloskey, 'The Patient Self-Determination Act' (1991) 1 *Institute of Ethics J.* 163; J. LePuma, 'Advance Directives on Admission: Clinical Implications and Analysis of the Patient Self-Determination Act' (1991) 266 *J.A.M.A.* 402. MO.

³²⁰ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions* 1982.

³²¹ President's Commission Report, 9-11.

³²² The commission made numerous recommendations aimed at upholding the right of an individual to refuse even life-sustaining medical treatment. See the President's Commission Report, 2-9 for a summary of the commission's conclusions.

³²³ *Id.* 60-77.

³²⁴ *Id.* 72.

³²⁵ *Ibid.*

prolongation of suffering.³²⁶ However, in the opinion of the commission, this possibility was insufficiently weighty to justify a change in legal policy:

In the final stages of some diseases, such as cancer, patients may undergo unbearable suffering that only ends with death. Some have claimed that sometimes the only way to improve such patients' lot is to actively and intentionally end their lives. If such steps are forbidden, physicians and family might be forced to deny these patients the relief they seek and to prolong their agony pointlessly.

If this were a common consequence of a policy prohibiting all active termination of human life, it should force a reevaluation of maintaining the prohibition. Rarely however, does such suffering persist when there is adequate use of pain relieving drugs and procedures.³²⁷

The commission also recognised that policies prohibiting direct killing may conflict with the important value of patient self-determination:

This conflict will arise when deliberate actions intended to cause death have been freely chosen by an informed and competent patient as the necessary or preferred means of carrying out his or her wishes, but the patient is unable to kill him or herself unaided, or others prevent the patient from doing so. The frequency with which this conflict occurs is not known, although it is probably rare. The Commission finds this limitation on individual self-determination to be an acceptable cost of securing the general protection of human life afforded by the prohibition of direct killing.³²⁸

And in an earlier part of the commission's report, where consideration was given to the possible liability of doctors under the criminal law, the commission stated that:

Since neither wrongful shortening of life by physicians nor the failure to give appropriate medical treatment for fear of the criminal law appears to be prevalent, society seems to be well served by retaining its criminal prohibition on killing, as interpreted and applied by reasonable members of the community in the form of prosecutors, judges and jurors.³²⁹

First, it should be noted that the commission's report was primarily concerned with the issue of forgoing life-sustaining treatment, so the commission's comments on the issue of legalising active voluntary euthanasia were simply incidental to its principal inquiry. It is therefore not unreasonable to suggest that the issue of active voluntary euthanasia may not have received as full and detailed consideration as it would deserve and further that the commission is unlikely to have had before it all the relevant evidence and information to make a fully informed decision on this difficult issue. The commission's report is nevertheless significant in that it is one of the few government inquiries in the common law jurisdictions under consideration to have given serious consideration to the issue of legalising active voluntary euthanasia performed in the medical context.

³²⁶ *Id.* 73.

³²⁷ *Ibid.*

³²⁸ *Ibid.*

³²⁹ *Id.* 35-36.

Central to the commission's rejection of active voluntary euthanasia is the concern that its legalisation would result in abuse and erosion of proper respect for human life. However, there is remarkably little argument or evidence of any kind to substantiate this assertion which in turn casts doubt on the commission's findings.³³⁰

The approach adopted by the commission does not purport to comment on the morality of active voluntary euthanasia. Rather, it seeks to ascertain whether there is sufficient justification to warrant some modification of the present criminal law prohibition on active termination of life within the medical context, and on this issue the commission was clearly of the view that there was insufficient evidence to justify a change of the law. The commission's determination on this issue raises certain matters which have earlier been considered in the preceding chapters³³¹ and no attempt will be made here to retrace that ground. Suffice it to say that the commission's conclusion on this issue was by no means the only conclusion that could have been reached.

Notwithstanding the commission's rejection of any change to the law, the willingness of the commission to accept the possible need to re-evaluate the present prohibition is of itself significant, reflecting recognition that the law's prohibition of direct killing is not finite or absolute and may require adaptation to meet changing circumstances. Further, it should be noted that since the commission released its report in 1983, there have been significant developments with regard to the issue of active voluntary euthanasia³³² which would arguably justify a different conclusion today.

Legislative Developments with Regard to Active Voluntary Euthanasia

Humane and Dignified Death Act 1988

In recent years attempts have been made in a number of States, to introduce 'physician aid-in-dying' legislation through the voter initiated referendum process. The first State to be targeted for reform was California because of its reputation as the bellwether State for many social reforms. The *Humane and Dignified Death Act 1988*³³³ sought, by amendment to the Californian Constitution, to extend the right of privacy to include the right of the terminally ill to physician-assisted aid-in-dying; (i.e. active voluntary euthanasia performed by a physician.) More particularly, the object of the legislation was to confer on all competent, terminally ill adults the right to request and receive voluntary, humane and dignified physician aid-in-dying under carefully defined circumstances.³³⁴ In order to achieve this objective, the Act sought to build on the existing law by enlarging the Californian *Natural Death Act 1976* and including a durable power of attorney of health care within the legislation.

³³⁰ E. Winkler, 'Forgoing Treatment: Killing vs. Letting Die and the Issue of Non-Feeding' in J. Thornton and E. Winkler, *Ethics and Aging* (1988) 155, 162.

³³¹ See chapter IV and V.

³³² See chapter VI.

³³³ Although widely referred to as an 'Act,' this legislation was never enacted.

³³⁴ For analysis of the legislation see R. Risley, *Death with Dignity* (1989) 47; D. Clarke, 'Physician Assisted Aid in Dying: A California Proposal' (1988) 2 *Euthanasia Rev.* 207.

In order to come within the scope of the proposed legislation, a competent adult would have to sign a directive in the presence of two disinterested witnesses.³³⁵ Before signing the directive, the patient would be required to inform his or her family and indicate that he or she has considered the family's opinion though the patient would retain the right of final decision provided he or she remained competent.³³⁶ In the directive, a patient would be required to specify that it was his or her wish that his or her life not to be prolonged artificially or that his or her life be ended with the help of a physician on request. The patient would also be required to designate an agent to make health care decisions on his or her behalf in the event that he or she becomes incompetent, and must specifically stipulate whether the agent has the power to request physician aid-in-dying on his or her behalf.³³⁷ Once duly executed, a directive would remain in effect for a period of seven years, but could be revoked at any time.³³⁸ A number of conditions would have to be met before a physician would legally be able to comply with a patient's directive.³³⁹ First, there would have to be a validly executed directive presently in force. Second, two physicians would have to certify that the patient's condition was 'terminal'.³⁴⁰ Third, if the patient became incompetent after being certified terminally ill, the patient's agent could request physician aid-in-dying on behalf of the patient but the decision would have to be reviewed by a three person ethics committee.³⁴¹ In this way, the proposed Act sought to make provision for physician aid-in-dying for patients who are no longer competent to make their own decisions.

The *Humane and Dignified Death Act* 1988 also proposed protection for physicians and other health care workers from civil, criminal and administrative liability when complying with the patient's directive in accordance with the legislation.³⁴² The legislation additionally provided that the failure of a physician to effectuate the directive would not give rise to liability. However, the wilful refusal by a physician to transfer the patient to a physician who would comply with the directive would constitute unprofessional conduct.³⁴³ Further, the Act provided that nothing in the legislation should be construed to condone, authorise or approve mercy killing or to permit any affirmative or deliberate act to end life except as provided for under the legislation.³⁴⁴

Whilst clearly following the format of the earlier living will legislation, the proposed *Humane and Dignified Death Act* 1988 represented a significant departure from any existing legislation in seeking

³³⁵ For reference to the *Humane and Dignified Death Act* 1988 see R. Risley and M. White, 'Humane and Dignified Death Initiative for 1988' (1986) 1 *Euthanasia Rev.* 226-237.

³³⁶ See the terms of the directive where this is recited.

³³⁷ Risley and White, 233.

³³⁸ *Id.* 229.

³³⁹ Risley, *Death with Dignity*, 48.

³⁴⁰ 'Terminal condition' was defined under the legislation as one which, regardless of application of life-sustaining procedures, is incurable and, within reasonable medical judgment, will lead to death within six months.

³⁴¹ Risley and White, 228-229.

³⁴² *Id.* 230.

³⁴³ *Id.* 230-231.

³⁴⁴ *Id.* 232-233.

to permit physician aid-in-dying (active euthanasia), subject to certain conditions and safeguards. The scope of the proposed legislation was potentially quite broad, permitting physician aid-in-dying at the request of a competent patient as well as providing a mechanism for the patient to appoint an agent to request aid-in-dying on his or her behalf in the event that he or she becomes incompetent. The Californian initiative drew considerable opposition from right-to-life and medical groups, including the Californian Medical Association, primarily on the grounds that legalisation of physician aid-in-dying would be too open to abuse to be justifiable. The initial attempt to introduce this legislation in California in 1988 was unsuccessful, due to a failure to collect the required number of signatures within the specified time frame to qualify the initiative for the ballot.³⁴⁵

Initiative 119, Washington 1991

The next State targeted for the introduction of legislation permitting physician aid-in-dying was Washington where the 'Death with Dignity Initiative' (also known as Initiative 119) was mounted. In May 1990, campaigners began to gather signatures in support of the petition for the introduction of legislation permitting physician aid-in-dying. Under Washington State law, a minimum of 150, 001 signatures must be collected in order to qualify an initiative for the referendum process. However, this number was far exceeded and a total of 223, 000 signatures was in fact collected, qualifying the initiative for the November 1991 ballot.³⁴⁶

The legislative proposal under Initiative 119 was similar to the *Humane and Dignified Death Act* 1988 which had been proposed in California.³⁴⁷ In order to qualify for physician aid-in-dying, a person would need to be examined by two physicians, one of whom must be the attending physician. Both physicians would have to certify that the patient's condition was 'terminal'.³⁴⁸ Further, the patient would need to indicate in writing a request for 'aid-in-dying'³⁴⁹ at the time such a medical procedure was desired and the request would need to be witnessed by two disinterested persons. Thus, the Washington initiative was clearly confined to competent patients requesting aid-in-dying on their own behalf. In this respect, this proposal was substantially narrower than the earlier Californian proposal.

³⁴⁵ This was later put down to a lack of funding and inexperience; see A. Parachini, 'The California Humane and Dignified Death Initiative' (1989) 19 *Hastings Center R.* 10, 11.

³⁴⁶ See the promotional literature published by Washington Citizens for Death with Dignity, 'Political History and Background of Initiative 119'.

³⁴⁷ The full title to this legislation was *An Act Relating to the Natural Death Act and Amending RCW 70.122.010, 70.122.020, 70.122.030, 70.122.040, 70.122.050, 70.122.060, 70.122.070, 70.122.080, 70.122.090, 70.122.100, and 70.122.900*. There were, in fact, two distinct components to Initiative 119; the aid-in-dying proposal which is discussed here and a proposal to extend the Washington *Natural Death Act* 1979 by clarifying that artificially administered nutrition and hydration is a life-sustaining procedure which may be withdrawn and extending the definition of 'terminal condition' to include irreversible coma and persistent vegetative state.

³⁴⁸ As under the earlier Californian proposal, 'terminal condition' was defined as an incurable or irreversible condition which in the opinion of the physicians, exercising reasonable medical judgment, will result in death within six months.

³⁴⁹ 'Aid-in-dying' was defined under the legislation to mean 'aid in the form of a medical service, provided in person by a physician, that will end the life of a conscious and mentally competent qualified patient in a dignified, painless and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the time the medical service is to be provided.'

The proposed legislation also provided that a directive could be revoked at any time and that no physician who provides aid-in-dying to a qualified patient in accordance with the provisions of the legislation shall be subject to prosecution or be guilty of any criminal act or unprofessional conduct. As under the Californian proposal, no health care facility or physician would be required to administer aid-in-dying. However, if the physician or facility was unwilling to do so, they would be required to transfer the patient to another health care facility and/or physician who would be willing to carry out the patient's request.

Proponents for Initiative 119 presented a sophisticated campaign and were supported by a variety of professional groups including clergy, lawyers, doctors, nurses, social workers and hospice workers.³⁵⁰ However, as with the earlier campaign in California, considerable opposition was encountered particularly from right-to-life groups and Roman Catholic Church leaders. In the build-up to the November ballot, these forces financed an aggressive television campaign against the initiative. The initiative was also opposed by the Washington State Medical Association.³⁵¹ Public opinion polls taken prior to the ballot suggested that the initiative would be successful. However, in a State-wide referendum held on the 5th of November 1991, the initiative was defeated by a narrow margin. Of some 1.3 million voters (apparently the biggest recorded turnout for a State referendum in Washington), 54% voted against with 46% in favour.³⁵²

For many the defeat of the initiative came as a surprise, particularly in the light of opinion poll results gathered over recent years which indicate majority support for active voluntary euthanasia. A number of factors can be advanced which may help to explain the referendum result.³⁵³ There is no doubt that the opposition's campaign against the initiative took its toll in the electorate.³⁵⁴ There was also some adverse publicity arising from the suicide of Anne Wickett, the former wife of Derek Humphry, the then Executive Director of the Hemlock Society and one of the key supporters of the legislation.³⁵⁵ There may have also been some public backlash to the activities of Jack Kevorkian and his 'suicide machine' which were again before the public in the period shortly prior to the November ballot.³⁵⁶ More fundamentally, some of those in the community who in principle support active voluntary euthanasia may not have been satisfied with the particular form of the proposal.³⁵⁷

³⁵⁰ For example, Washington Citizens for Death with Dignity; the Interfaith Clergy for Yes on Initiative 119; Lawyers for Yes on Initiative 119; Nurses for Yes on Initiative 119; and Physicians for Yes on Initiative 119.

³⁵¹ In a random survey of its membership, 51% of the 2,000 respondents voted to oppose the initiative, with 49% in support. In the light of this close poll result, the association did not initially campaign against the initiative. However, following a House of Delegates vote against the measure and with support from the American Medical Association, it embarked, quite late in the piece, on a campaign against the legislation; *Am. Med. News* 18 Nov. (1991).

³⁵² *N.Y. Times* 7 Nov. 1991.

³⁵³ R. Carson, 'Washington's I-119' (1992) *Hastings Center R.* 7.

³⁵⁴ Note, 'Fear Campaign Beat the Washington Initiative' (1992) 46 *Hemlock Q.* 5. The Washington State Attorney-General has since filed suit against the 119 Vote No! Committee, alleging that the committee made false claims in a pamphlet circulated about a week before the election; *Hemlock News* July-August 1992.

³⁵⁵ Note, 'Washington State Euthanasia Moves Fails' (1992) Vol. 11 No. 2 *Bioethics News* 4-5.

³⁵⁶ *Ibid.*

³⁵⁷ There were, for example, complaints that the legislative proposal was loosely worded and lacked a precise regulatory mechanism for the practice of physician aid-in-dying.

Notwithstanding its defeat, Initiative 119 was an historic development, being the first time ever that voters have had the opportunity to pass electoral judgment on the subject of active voluntary euthanasia. The initiative was also significant for the widespread support it received from a variety of professional groups. It must also be emphasised that although it was ultimately unsuccessful, it was supported by a substantial minority and the final result was very close indeed.

Death with Dignity Act 1992

The campaign to introduce physician aid-in-dying legislation in the United States has continued. In California a coalition has been formed between Hemlock chapters in that State, and the organisation Americans Against Human Suffering (California Coalition for Death with Dignity),³⁵⁸ to campaign for the introduction of physician aid-in-dying legislation. The legislation, a slightly modified version of the earlier *Humane and Dignified Death Act* 1988 (renamed the *Death with Dignity Act*³⁵⁹) was sufficiently supported to qualify it for the ballot.³⁶⁰ The proposal, known as Proposition 161, was narrowly defeated in the November 1992 ballot by 54% to 46% - exactly the same margin as for the Washington Initiative 119.³⁶¹

The Californian initiative differed from the Washington proposal in a number of respects. One additional requirement under the Californian proposal was that the request for aid-in-dying had to be an 'enduring request'.³⁶² It also had provision for psychological counselling and record keeping and required that the family must be informed of the patient's intent.³⁶³ As under the earlier Californian proposal, the legislation provided for the appointment of a health care attorney who can make decisions on behalf of the patient in the event that the patient becomes incompetent, including a request for aid-in-dying. In this respect the legislation was broader than the Washington proposal.

Private Members' Bills

In addition to these developments based on the citizen initiated referendum process, active voluntary euthanasia legislation has also been introduced in a number of American States. During 1992, Bills were introduced in the legislatures of New Hampshire, Maine and Iowa. The New Hampshire Bill³⁶⁴

³⁵⁸ For details regarding the 'California Coalition for Death with Dignity' (comprised of Hemlock chapters in that State and Americans Against Human Suffering) and the proposed legislation see Note, 'Three States Move to Legalize Physician Aid-in-Dying' (1989) 36 *Hemlock Q.* 1. Plans are also underway for the introduction of a similar initiative in Oregon in 1994; *Medical Tribune* 28 Nov. 1991.

³⁵⁹ See Risley, *Death with Dignity*, Appendix A for reference to the proposed legislation and Appendix B for analysis of the legislation.

³⁶⁰ Note, 'California Campaign Off to a Good Start' (1992) 46 *Hemlock Q.* 1. A minimum of 600,000 signatures had to be gathered before the end of March 1992. The 'death with dignity' proposal received considerable support from a number of quarters, including the State Bar of California's House of Delegates which adopted an amended version of the legislation at the recommendation of the Beverly Hill Bar Association; J. Podgers, 'Matters of Life and Death: Debate Grows Over Euthanasia' (1992) 78 *A.B.A.J.* 60, 61.

³⁶¹ D. Gianelli, 'Euthanasia Measure Fails, But Backers Vow Renewed Push' *Am. Med. News* (Nov. 23/31) (1992) 30.

³⁶² *Ibid.*

³⁶³ *Ibid.*

³⁶⁴ *An Act Relative to Death with Dignity for Certain Persons Suffering Terminal Illness* 1992.

allows a mentally competent person who is 18 years of age or older and who has been diagnosed as having a terminal condition³⁶⁵ to request that his attending physician, after consultation with a second physician competent in the appropriate category of expertise, prescribe medication which will enable the patient to control the time, place and manner of his or her death. The Bill does not require any physician, health care personnel or health care facility to participate in the request, but does require a good faith effort to transfer a patient to another physician or facility. Under this Bill, the request is witnessed and signed in essentially the same manner as a living will. The Bill requires a review by an ethics committee or similar body of a health care facility before the patient's request is honoured. This Bill was referred for Interim Study by the House Judiciary Committee. Public hearings and work sessions were held in September 1992, and at the time of writing, a determination was yet to be made whether the Bill has sufficient merit to be redrafted and introduced for the 1993 parliamentary session.

The Bill introduced in the Maine legislature³⁶⁶ seeks to amend the living will legislation in that State to allow for a medically assisted death in certain limited circumstances. The Bill allows a person, who is at least 18 years of age, and who has been diagnosed with a terminal condition, to request a medically assisted death. Two consulting physicians must independently certify the individual's condition before a medically assisted death may proceed. If both consulting physicians certify that the individual has an incurable and irreversible condition, the individual's attending physician, any other physician and any health care facility are authorised to assist the individual with a medically assisted death.

Finally, the Iowa Bill³⁶⁷ provides for the execution of a declaration by qualified patients³⁶⁸ which allows the provision for assistance-in-dying to the declarant. The Bill stipulates requirements for a valid declaration, including a requirement that two people must witness the execution of the declaration, that two physicians must attest to the condition of the declarant as terminal,³⁶⁹ and that the declaration will not be effectuated unless the declarant is conscious and competent at the time that assistance-in-dying is to be provided.

The introduction of these three Bills heralds a new era in the campaign for the introduction of legislation permitting active voluntary euthanasia in the United States. The Bills proposed in Maine and Iowa provide for medically assisted death along similar lines to the legislation which has been proposed in Washington and California under the citizen initiated referendum process. The New

³⁶⁵ 'Terminal condition' is defined in the legislation to mean an incurable and irreversible condition, the end stage of a disease for which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and a second physician competent in that disease category, both of whom shall have personally examined the patient, will result in death.

³⁶⁶ *An Act Regarding the Terminally Ill* 1992.

³⁶⁷ *An Act Relating to the Provision of Assistance-in-Dying, and Providing Penalties* 1992.

³⁶⁸ 'Qualified patient' is defined as a patient who has been diagnosed to be in a terminal condition by two physicians.

³⁶⁹ 'Terminal condition' is defined as an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of two physicians having examined the patient and exercising reasonable medical judgment, result in the death of the patient within six months.

Hampshire Bill is somewhat more circumscribed, dealing only with physician-assisted suicide. The legislative scheme in all three jurisdictions includes an immunity for physicians who act upon a patient's request in accordance with the legislation.

Canada

There have also been significant developments in Canada in the past ten years. The Canadian Law Reform commission has specifically addressed the issue of active voluntary euthanasia and there have been law reform inquiries as well as legislative developments in a number of Canadian Provinces with regard to both active and passive euthanasia.

Law Reform Commission of Canada

The Law Reform Commission of Canada has undertaken extensive work in the area of medical law and ethics, in connection with its Protection of Life Project.³⁷⁰ In 1982, the commission published a working paper *Euthanasia, Aiding Suicide and the Cessation of Treatment* to address what it saw as a real interest and need in this area.³⁷¹ Three basic questions were asked by the commission: (1) should active euthanasia be legalised, or at least decriminalised?; (2) should aiding suicide be decriminalised?; and (3) should the Canadian *Criminal Code* be revised to define the legal parameters of the refusal and cessation of treatment?³⁷² The formulation of the questions in these terms is in itself significant, in that the issue of medically administered voluntary euthanasia³⁷³ was directly considered by the commission. This is in contrast to the government and law reform commission inquiries into the criminal law undertaken in Australia and the United Kingdom which have focussed attention on the more general question of mercy killing.³⁷⁴ The working paper released by the commission set out some preliminary proposals with regard to the matters under consideration, which were largely incorporated in the commission's 1983 report.³⁷⁵

³⁷⁰ In 1976, a special study group was established called the Protection of Life Project, which has over the years, examined various topics including abortion, sterilisation, criteria for determining death and consent to medical treatment.

³⁷¹ Law Reform Commission of Canada, Working Paper No. 28, *Euthanasia, Aiding Suicide and the Cessation of Treatment* (1982) Foreword. (hereafter referred to as the Law Reform Commission of Canada, Euthanasia Working Paper).

³⁷² *Id.* 32, 43.

³⁷³ The definition used by the commission was 'the act of ending the life of a person from compassionate motives, when he is already terminally ill or when his suffering has become unbearable'; Law Reform Commission of Canada, Report No. 20, *Euthanasia, Aiding Suicide and the Cessation of Treatment* (1983) (hereafter referred to as the Law Reform Commission of Canada, Euthanasia Report.) 17.

³⁷⁴ The issue of mercy killing has also been the subject of earlier consideration by the Canadian Law Reform Commission; see Canadian Law Reform Commission Working Paper No. 33, *Homicide* (1984) where it was proposed that mercy killing should be taken out of the category of first-degree murder. For discussion, see B. Sneiderman, 'Why Not a Limited Defence? A Comment on the Proposals of the Law Reform Commission of Canada on Mercy Killing' (1985) 15 *Man.L.J.* 85.

³⁷⁵ Law Reform Commission of Canada, Euthanasia Report.

The issues of active euthanasia and aiding suicide were dealt with quite summarily by the commission.³⁷⁶ The commission recommended against legalising or decriminalising active voluntary euthanasia in any form and was in favour of continuing to treat it as culpable homicide. The reasons for this view were stated in the report:

The legalization of euthanasia is unacceptable to the Commission because it would indirectly condone murder, because it would be open to serious abuses, and because it appears to be morally unacceptable to the majority of the Canadian people. The Commission believes that there are better answers to the problems posed by the sufferings of the terminally ill. The development of palliative care and the search for effective pain control methods constitutes a far more positive response to the problem than euthanasia on demand. To allow euthanasia to be legalized, directly or indirectly, would be to open the door to abuses and hence indirectly weaken respect for human life.³⁷⁷

With regard to the more general question of mercy killing, the commission recommended that mercy killings should not be made an offence separate from homicide and that there be no formal provision for special modes of sentencing for this type of killing other than what is already provided for homicide.³⁷⁸ The commission further recommended against decriminalising aiding suicide for much the same reasons that it did not favour the legalisation of active voluntary euthanasia.³⁷⁹

The bulk of the commission's report dealt with the third area, concerning the cessation and refusal of treatment.³⁸⁰ After considering living will legislation adopted in California and some other American States, the commission rejected this legislative approach on the grounds that it would risk the reversal of the already established rule that there should be no duty to initiate or maintain treatment when it is useless to do so.³⁸¹ The commission did, however, believe it necessary to introduce amendments to the *Criminal Code* giving formal and explicit recognition to the right of a competent patient to refuse treatment of any kind and at the same time, conferring appropriate protection upon medical personnel involved in the withholding and cessation of treatment and the administration of palliative care.

In order to address concerns amongst members of the medical profession that the cessation of treatment may be grounds for civil and criminal liability, it was recommended by the commission that the *Criminal Code* be amended to make it clear that it is lawful for a doctor to comply with the expressed wishes of patients regarding the course of their treatment and also to discontinue treatment which has become therapeutically useless and is not in the best interests of the patient.³⁸² However, the commission decided against the creation of a new criminal offence for doctors who treat patients against their wishes.³⁸³

³⁷⁶ *Id.* 17-21.

³⁷⁷ *Id.* 18. See also the Law Reform Commission of Canada, Euthanasia Working Paper for consideration of the arguments for and against legalisation; 44-48.

³⁷⁸ Law Reform Commission of Canada, Euthanasia Report, 18-20.

³⁷⁹ *Id.* 20-21.

³⁸⁰ *Id.* 22-28.

³⁸¹ Law Reform Commission of Canada, Euthanasia Working Paper, 69; the Law Reform Commission of Canada, Euthanasia Report, 23-28.

³⁸² Law Reform Commission of Canada, Euthanasia Report, 32.

³⁸³ *Id.* 22.

Legal concerns had also been raised before the commission, regarding the administration of drugs in palliative care which may shorten the patient's life expectancy. In particular, there was concern that certain provisions of the *Criminal Code* may prevent a doctor from undertaking or continuing necessary palliative care, because the dosage for effective pain relief may hasten the death of the patient.³⁸⁴ It was accordingly recommended that it be specified in the *Criminal Code* that a doctor cannot be held criminally liable merely for undertaking or continuing the administration of palliative care in order to eliminate or reduce the suffering of an individual for the sole reason that such care or measures are likely to shorten the life expectancy of the patient.³⁸⁵

The commission's report met with a mixed reaction. It has generally been welcomed for its efforts to clarify the legal status of initiating and ending life-supporting medical treatment and the administration of palliative care.³⁸⁶ The report has, however, been subject to criticism for its treatment of the euthanasia issue.³⁸⁷ It is certainly true that the report merely recites the well established arguments for and against active voluntary euthanasia including concerns about the risk of abuse, without really advancing the debate or providing any evidence to substantiate such claims. More fundamentally, however, in its forthright rejection of any change to the law with regard to active voluntary euthanasia, and in particular, in the assertion that legalisation of active voluntary euthanasia 'appears to be morally unacceptable to the majority of the Canadian people,' the report ignores important evidence of growing public opinion in Canada in favour of legalisation of medically administered active voluntary euthanasia.³⁸⁸ Furthermore, it could be argued that the commission, in rejecting any change, has underestimated the significance of the existing discrepancy between law and practice in this area, and the problems resulting from this discrepancy.³⁸⁹

In 1987, the Law Reform Commission of Canada, in its report *Recodifying Criminal Law - Revised and Enlarged Edition*, made recommendations for the implementation of its earlier proposals with regard to the withholding or withdrawing of treatment or the administration of palliative care.³⁹⁰ At the time of writing these recommendations had not been implemented.

³⁸⁴ *Id.* 35.

³⁸⁵ *Id.* 22-23. The Canadian Law Reform Commission subsequently reiterated these recommendations in its Report, *Some Aspects of Medical Treatment and the Criminal Law* (1986).

³⁸⁶ For example, J. Baudouin, 'Cessation of Treatment and Suicide: A Proposal for Reform' (1982) 3 *Health Law in Canada* 72; W. Curran, 'Quality of Life and Treatment Decisions: The Canadian Law Reform Commission Report' (1984) 310 *New Eng J.Med.* 297; Note, 'Treatment Decisions and the Third Alternative' (1984) 32 *J.Am. Geriatrics Society* 483.

³⁸⁷ For example, R. Samek, 'Euthanasia and Law Reform' (1984) 17 *Ottawa L.Rev.* 86; L. Schiffer, 'Euthanasia and the Criminal Law' (1985) 42 *U. Toronto Fac.L.Rev.* 91.

³⁸⁸ See chapter VI, 235-236.

³⁸⁹ For example, the omission relies upon the internal regulating mechanisms to offset the apparent harshness of the law as an argument in favour of retaining the existing prohibition when this is in fact one of the strongest arguments for change. See also Schiffer, 108.

³⁹⁰ Law Reform Commission of Canada, Report No. 31, *Revised and Enlarged Edition of Report 30, Recodifying Criminal Law* (1987). See draft s. 6(2) (no person is criminally liable for an omission to provide or continue medical treatment that is therapeutically useless or medical treatment for which consent is expressly refused or withdrawn) and draft s. 42 (to the effect that the Code provisions with regard to homicide and suicide do not apply in respect of the administration of palliative care that is appropriate in the circumstances to control or eliminate the pain and suffering of a person regardless of whether or not the palliative care reduces the life expectancy of that person, unless that person refuses

Apart from the work of the Canadian Law Reform Commission, there have been a number of other interesting developments in recent years relevant to the issue of euthanasia. One noteworthy development has been the increasing interest and activity in Canada with regard to advance directives and durable powers of attorney for health care. In 1990, the Manitoba Law Reform Commission commenced an inquiry into self-determination in health care. The aim of this inquiry was to determine whether the law should be reformed to permit the creation of a mechanism which would give legal effect to the wishes of a formerly competent patient and if so, to determine the most appropriate mechanism for giving effect to health care decisions.³⁹¹ In its report released in June 1991, the commission recommended that the law should be reformed so as to give legally binding effect to the previously expressed wishes of a person who lacks the capacity to make decisions about medical treatment.³⁹² The commission proposed that the law should recognise a new document to be called the health care directive in which an individual can set out his or her wishes for future medical treatment and/or name another person to make health care decision on his or her behalf. At the time of writing steps were underway for the legislative implementation of these recommendations. Similar reviews have been undertaken in other Canadian jurisdictions.³⁹³

In a number of Provinces, legislation has already been passed validating the durable power of attorney for health care³⁹⁴ and legislation is currently being considered in a number of other Provinces. For example, in Ontario, there has been considerable legislative activity. In 1991, a number of Private Members' Bills were introduced which had the support of the three political parties.³⁹⁵ They were, however, superseded by more comprehensive legislation introduced by the New Democratic Party government in May 1991.³⁹⁶ This legislation, comprised of two separate Bills³⁹⁷ providing for durable health care power of attorney and living wills respectively, passed second reading and was referred to the Justice Committee for public input.³⁹⁸ Following extensive public hearings the Bills are again before the Ontario legislature and it is expected that this legislation will be enacted.³⁹⁹

At the federal level, attempts have been made to amend the criminal law regarding the care of terminally ill patients. In May 1991, Robert Wenman introduced in federal Parliament a Private

to consent to that care.) For a discussion of this latter recommendation, see D. Caswell, 'Rejecting Criminal Liability for Life-Shortening Palliative Care' (1990) 6 *J. Contemp. Health Law & Pol'y*. 138.

³⁹¹ Manitoba Law Reform Commission, *Discussion Paper on Advance Directives and Durable Powers of Attorney for Health Care* (1990).

³⁹² Manitoba Law Reform Commission, Report, *Self-Determination in Health Care (Living Wills and Health Care Proxies)* (1991).

³⁹³ See, for example, the Law Reform Commission of Saskatchewan, *Proposals for an Advance Health Care Directives Act* (1991); the British Columbia Royal Commission on Health Care and Costs, Report, *Closer To Home* (1991); Law Reform Commission of Newfoundland, *Discussion Paper on Advance Health Care Directives and Attorneys for Health Care* (1992).

³⁹⁴ For example, Nova Scotia and Quebec (following amendments to the Quebec Civil Code.)

³⁹⁵ Note, 'President's Corner' (1991) Vol. 8 No. 3. *Dying with Dignity Newsletter* 2.

³⁹⁶ *Ibid.*

³⁹⁷ Bill 108; *An Act to Provide for the Making of Decisions on Behalf of Adults Concerning the Management of their Property and Concerning their Personal Care*, and Bill 109; *An Act Respecting Consent to Medical Treatment*.

³⁹⁸ Note, 'President's Corner' (1991) Vol. 9 No. 1. *Dying with Dignity Newsletter* 2.

³⁹⁹ *Ibid.*

Member's Bill which sought to give effect to the recommendations of the Canadian Law Reform Commission in its Report *Euthanasia, Aiding Suicide and Cessation of Treatment*.⁴⁰⁰ However, this Bill was not supported by the government and lapsed in committee.⁴⁰¹ The failure of this piece of legislation was widely attributed to it having been introduced as a Private Member's Bill.

Physician-Assisted Suicide and Active Voluntary Euthanasia

Apart from these initiatives which deal principally with providing mechanisms for decision-making for competent patients in the event of future incompetence, growing interest has focused on physician-assisted suicide and active voluntary euthanasia. In 1991, the British Columbia Royal Commission on Health Care released a report which proposed an amendment to the *Criminal Code* that would exempt health care workers from criminal liability for assisting the suicide of a terminally ill patients.⁴⁰² The issue of active voluntary euthanasia was also considered and although a number of the commissioners believed that health care workers should be protected from criminal charges if they assisted terminally ill patients in ending their lives, a consensus could not be reached and no recommendations were made.⁴⁰³ This report is significant, being the first Canadian report where physician-assisted suicide is unequivocally endorsed and where there is some qualified support from some commissioners for the legalisation of active voluntary euthanasia.

In other developments, steps have been taken in one Canadian Province for the legalisation of active voluntary euthanasia. In 1991, a Private Member's Bill for the legalisation of active voluntary euthanasia was introduced into the Ottawa House of Commons by Chris Axworthy.⁴⁰⁴ Under the terms of the proposed legislation, a person suffering from an irremediable condition could make application (on a specific form, witnessed by two people who are not related to the applicant) and accompanied by a medical certificate signed by the attending physician. This document would then be presented to a 'referee' appointed by the Attorney-General, and a decision would have to be made within five days of receipt. If the application were to be approved, a euthanasia certificate would be issued with a copy to the patient's doctor. Only qualified medical practitioners would be authorised to administer active euthanasia under the legislation and they would be protected from criminal liability, provided the administration of active euthanasia was performed with reasonable skill and care. The Bill also sought to clarify the law with regard to the administration of pain-killing treatment which may have the effect of hastening death and the issue of withholding or withdrawing of treatment at the patient's request or in circumstances where the treatment is therapeutically useless.⁴⁰⁵ Although the Bill was generally welcomed by proponents of active voluntary euthanasia, the terms of the Bill and

⁴⁰⁰ Bill C-203; *An Act to Amend the Criminal Code (Terminally Ill Persons)* 1991. For discussion of the original recommendations, see above, 345-347.

⁴⁰¹ Note, 'President's Corner' (1992) Vol. 9 No. 2 *Dying with Dignity Newsletter* 2, 4.

⁴⁰² British Columbia Royal Commission on Health Care and Costs, *Closer To Home* C-183.

⁴⁰³ *Ibid.*

⁴⁰⁴ *Euthanasia and Cessation of Treatment Act* 1991; see Note, 'Euthanasia Legislation' (1991) Vol. 8 No. 3 *Dying with Dignity Newsletter* 1-2.

⁴⁰⁵ Explanatory Note. See also discussion in Note, 'Euthanasia Legislation'.

in particular the proposal for a euthanasia referee did not attract much support.⁴⁰⁶ This Bill was defeated in the House of Commons.⁴⁰⁷

International Developments

Although this thesis has principally focused on the Australian position, with attention also being given to a number of other common law jurisdictions, a number of developments at the international level also merit brief consideration in the light of their broader implications.

Until recently, the issue of euthanasia, and in particular the issue of active voluntary euthanasia, had received little attention at the international level.⁴⁰⁸ There have, however, been a number of recent developments of some significance including preliminary consideration of the issue of active voluntary euthanasia by a committee of the Council of Europe and attempts to introduce legislation in support of active voluntary euthanasia in the European Parliament.

Council of Europe

In 1987, the issue of active voluntary euthanasia was raised before the Council of Europe by the Netherlands government. The Netherlands government was at the time considering the introduction of legislation dealing with active voluntary euthanasia and had sought advice on the subject from the Council of Europe.⁴⁰⁹ The matter was referred to a working party of the Ad Hoc Committee of Experts on Progress in Biomedical Science of the Council of Europe (C.A.H.B.I.). Questionnaires on euthanasia, prepared by the secretariat in collaboration with experts from the Netherlands were sent to all member States as well as those non-member States that have observer status with the C.A.H.B.I. Under its terms of reference, the working party was instructed to examine the replies received to this questionnaire and to prepare a draft opinion on euthanasia. In particular, the working party was requested to give an opinion of the feasibility and the desirability of undertaking a study of the legal, human rights, ethical and medical problems relating to euthanasia.

On the basis of the opinion provided by the working party, the C.A.H.B.I. reached the conclusion that whilst it would be possible to undertake a study on problems relating to active euthanasia, (which it defined as a deliberate act to end the life of a severely suffering patient at his or her request) such a

⁴⁰⁶ Note, 'Forum Draws Good Crowd' (1992) Vol. 9 No. 1 *Dying with Dignity Newsletter* 3.

⁴⁰⁷ *Ibid.*

⁴⁰⁸ In 1976, the Parliamentary Assembly of the Council of Europe recommended the establishment of national commissions of inquiry to lay down ethical rules for the treatment of persons approaching the end of life and which would consider, *inter alia*, the situation which may confront members of the medical profession, such as legal sanctions whether civil or penal, when they have refrained from effecting artificial measures to prolong the death process in the case of terminal patients whose lives cannot be saved by present day medicine, or have taken positive measures whose primary intention was to relieve suffering in patients and which could have a subsidiary effect on the process of dying. Recommendation 779 (1976). For discussion see D. Costello, 'The Terminally Ill - The Law's Concerns' (1986) 21 *Ir. Jurist* 35.

⁴⁰⁹ For further discussion, see chapter VIII, 377.

study was not appropriate or timely.⁴¹⁰ A report was subsequently submitted by the Secretary General of the Council of Europe to the 16th Conference of European Ministers of Justice relating to the work of the C.A.H.B.I. With regard to the problems relating to active voluntary euthanasia, it was reported that in December 1987, the C.A.H.B.I. adopted an opinion for the Committee of Ministers on the feasibility and the desirability of undertaking a study on the legal, human rights, ethical and medical problems relating to euthanasia (in particular 'giving death on request') and that, in this very detailed opinion, the conclusion was reached that such a study, even if it is feasible, is not desirable.⁴¹¹

European Parliament

In 1989, a Dutch member of the European Parliament, Mrs Van Hemeldonck, proposed a resolution on the care of the terminally ill. The matter was referred to committee and a report ensued dealing with the treatment of terminally ill patients. The report, authored by Leon Schwartzberg, Professor of Medicine and world renowned cancer specialist, contains a clause supporting active voluntary euthanasia.⁴¹² That clause provides:

In the absence of any curative treatment, and following the failure of palliative care correctly provided at both a psychological and medical level, each time a fully conscious patient insistently and repeatedly requests an end to an existence which has for him been robbed of all dignity and each time a team of doctors created for that purpose establishes the impossibility of providing further specific care, the request should be satisfied without thereby involving any breach of respect for human life.⁴¹³

The Schwartzberg report, as it has become known, was narrowly adopted by the European Parliament's Environment, Public Health and Consumers Committee in June 1991, but has not yet been debated in plenary sitting.⁴¹⁴ Debate in the European Parliament on the report was originally scheduled to take place later in 1991 but has been postponed on a number occasions. If the parliament adopts the resolution, active voluntary euthanasia will have received substantial European support.⁴¹⁵ However, the resolution will have no legal effect unless members of the European Parliament can persuade the European Commission to draft legislation which, if approved by the Council of Ministers, would be binding on member States.⁴¹⁶

⁴¹⁰ Council of Europe, Ad Hoc Committee of Experts on Progress in Biomedical Science (C.A.H.B.I.), *Draft Opinion on the Legal, Human Rights, Ethical and Medical Problems Relating to Euthanasia* Oct. (1987).

⁴¹¹ Report submitted by the Secretary General of the Council of Europe to the 16th Conference of European Ministers of Justice relating to the work of the C.A.H.B.I.

⁴¹² Note, 'Euthanasia and the European Parliament' (1991) 43 *V.E.S. Newsletter* 1.

⁴¹³ Extract from the motion for a resolution on care of the terminally ill. See Note, 'European Support for Euthanasia?' (1991) 69 *Bull. Med. Ethics* 25, 26.

⁴¹⁴ Written communication with the principal administrator of the Directorate General for Research of the European Parliament, Oct. 1992.

⁴¹⁵ *Id.* 25.

⁴¹⁶ Note, 'Euthanasia and the European Parliament' (1991) 43 *V.E.S. Newsletter* 1.

Conclusion

The foregoing analysis of reform developments with regard to active voluntary euthanasia in Australia and other common law jurisdictions under consideration reveals significant progress in recent years. An important indication of this development is the position taken by the Scottish Institute of Medical Ethics working party in its 1990 discussion paper in which it unequivocally endorsed the practice of assisted death in some limited circumstances. The subject of active voluntary euthanasia has been considered by the South Australian Select Committee on the law relating to death and dying. It has also been considered by the President's Commission in the United States and the Law Reform Commission of Canada. Although these bodies rejected any change to the law, their analysis of the issue has undoubtedly been an important development. The recent report of the British Columbia Royal Commission on Health Care is also of interest, for its endorsement of doctor-assisted suicide and the indications of support from a number of commissioners for a change to the law with regard to active voluntary euthanasia. The issue of active voluntary euthanasia has also indirectly received attention as a result of a number of criminal law inquiries dealing with the issue of mercy killing and law reform commission and parliamentary inquiries dealing with patients' rights and the subject of death and dying.

Although, to date, legislative enactments have been confined to the right of patients' to refuse treatment and to prepare an advance directive, they have nevertheless drawn attention to the issue of active voluntary euthanasia, and they evidence a willingness to respond to a growing demand for greater control over the manner of our dying. Specific steps have also been taken towards securing legislative reform with regard to active voluntary euthanasia. This has been the case particularly in the United Kingdom, initially through the efforts of the Voluntary Euthanasia Society, and now supported independently by an all-party parliamentary group on voluntary euthanasia. There have also been a number of important developments in the United States. The citizen initiated referendum process has been invoked in a number of States in an attempt to secure the legalisation of active voluntary euthanasia (or 'physician aid-in-dying' as it is often referred to in that jurisdiction.) In addition, there have been a number of Private Members' Bills seeking the legalisation of physician assisted suicide or active voluntary euthanasia. In sum, as a result of a variety of interrelated developments, Australia and the other jurisdictions under consideration appear now to be increasingly receptive to the legalisation of active voluntary euthanasia and this development is reflected in the interest that the subject of voluntary euthanasia has received internationally.

What has, however, been lacking in most considerations of the issue of active voluntary euthanasia has been a detailed analysis of the position in the Netherlands, where, for some time now, active voluntary euthanasia has been practiced relatively openly by the medical profession. This omission has tended to undermine the categorical rejection of active voluntary euthanasia by a number of law reform commission bodies and agencies on the grounds that they have based their conclusions on

supposition, for example, about feared consequences of legalisation, and have failed to take into account the available evidence. In the chapter which follows, the position in the Netherlands will be examined with a view to learning from the Netherlands' experience.

CHAPTER VIII

THE NETHERLANDS

Introduction

The country which has come closest to the legalisation of active voluntary euthanasia is the Netherlands. Although active voluntary euthanasia is still illegal in that country, it is now practised quite openly by the medical profession and there are very few prosecutions of doctors involved in the practice. Developments in the Netherlands have naturally attracted interest in Australia and other countries where there is growing pressure for the legalisation of active voluntary euthanasia. The Dutch position is often cited by proponents for active voluntary euthanasia as a model of social reform which demonstrates the benefits of sanctioned active voluntary euthanasia and which ought to be followed in other countries.¹ The object of this chapter is to examine the legal position and practice of active voluntary euthanasia in the Netherlands.

There is no doubt at all that the Netherlands offers a unique opportunity to those interested in the legalisation of active voluntary euthanasia to assess the effects of State sanctioned active voluntary euthanasia upon the law, medicine, health care and social policy.² In essence, the practice of active voluntary euthanasia in the Netherlands constitutes a social experiment³ which is open to analysis and may provide important lessons in any future attempts to legalise active voluntary euthanasia in other countries.

There has, for some time, been some difficulty in obtaining reliable information about the practice of euthanasia in the Netherlands, not the least of which has been the language barrier and the lack of scholarly literature on the Dutch position available in English. In more recent years, however, as interest in the Netherlands has heightened, attempts have been made to rectify this situation and there have been quite a number of publications in English dealing with the Dutch position.⁴ Many of these

1 For example, H. Kuhse, 'Voluntary Euthanasia in the Netherlands' (1987) 147 *M.J.A.* 394.

2 B. Bostrom, 'Euthanasia in the Netherlands: A Model for the United States?' (1989) 4 *Issues Law & Med.* 467, 470; J. Keown, 'The Law and Practice of Euthanasia in the Netherlands' (1992) 108 *Law Q.Rev.* 51, 77.

3 Bostrom, 470.

4 See, for example, the journal *Issues in Law and Medicine* which dedicated an entire issue to reporting the facts on the practice of active voluntary euthanasia in the Netherlands; 'Euthanasia in the Netherlands' (1988) 3 *Issues Law & Med.* 361 and the recent issue in the *Hastings Center Report* Vol. 22 March-April (1992). For Dutch commentators, see, for example, H. Rigter, E. Borst-Eilers and H. Leenen, 'Euthanasia Across the North Sea' (1988) 297 *B.M.J.* 1593; B. Sluyters, 'Euthanasia in the Netherlands' (1989) 57 *Medico-Legal J.* 34; J. Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands' (1987) 1 *Bioethics* 156; H. Leenen, 'Supreme Court's Decisions on Euthanasia in the Netherlands' (1986) 5 *Med. & Law* 349; H. Leenen, 'Dying with

items have been written by Dutch scholars and have subsequently been translated into English. There has also recently been a major government commissioned inquiry into medical decisions affecting the end of life which has produced the most comprehensive information to date about the practice of euthanasia in the Netherlands.

The Legal Position in the Netherlands

The present legal position in the Netherlands with regard to active voluntary euthanasia is very complex. Contrary to popular belief, active voluntary euthanasia has not actually been legalised and doctors engaging in the practice do so in violation of the Dutch *Penal Code* 1886.⁵ In practice, however, they are not prosecuted, provided that they can show that their actions in performing voluntary euthanasia were in accordance with certain guidelines which have been developed by the courts.⁶ Thus, through a combination of jurisprudential developments and prosecution policy, a situation has been reached where there is *de facto* conditional legal tolerance of active voluntary euthanasia in the Netherlands.

The official definition of euthanasia in the Netherlands is the deliberate termination of an individual's life by another, at that individual's request,⁷ and this definition is now widely accepted in that country. This definition is not only linked with the concept of self-determination but also with the legal definition of euthanasia in the Dutch *Penal Code* 1886.⁸ Specifically excluded from the definition of euthanasia are: the withholding or withdrawing of treatment which is medically pointless; the administration of necessary pain-relieving drugs which may shorten life; and the withholding or withdrawing of treatment at the patient's request.⁹ It follows from the Dutch definition of euthanasia that it necessarily refers to *voluntary* euthanasia (indeed the Dutch regard the notion of non-voluntary or involuntary euthanasia a contradiction in terms) and it involves *active* steps in the termination of life. However, in the interests of consistency with other chapters of this thesis, the phrase 'active voluntary euthanasia' will continue to be used for the purposes of this chapter.

Dignity: Developments in the Field of Euthanasia in the Netherlands' (1989) 8 *Med. & Law* 517; H. Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands' (1987) 8 *Health Policy* 197; H. Roscam Abbing, 'Dying with Dignity, and Euthanasia: A View from the Netherlands' (1988) 4 *Journal of Palliative Care* 70; M. de Wachter, 'Active Euthanasia in the Netherlands' (1989) 262 *J.A.M.A.* 3316.

⁵ See Article 293. See also Rigter, Borst-Eilers and Leenen, 1593.

⁶ Rigter, Borst-Eilers and Leenen, 1593.

⁷ State Commission on Euthanasia, The Hague, (1985). See also Royal Dutch Medical Association, Central Committee, *Vision on Euthanasia* (1986) (hereafter referred to as the Royal Dutch Medical Association, *Vision on Euthanasia*). For commentators in support, see also H. Leenen, 'Euthanasia in the Netherlands' in P. Byrne, (ed.) *Medicine, Medical Ethics and the Value of Life* (1990) 1, 2-4; E. Borst-Eilers, 'The Status of Physician-Administered Active Euthanasia in the Netherlands', paper presented at the Second International Conference on Health Law and Ethics, London, 16-21 July (1989) 2.

⁸ H. Leenen, 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients' in Royal Dutch Medical Association, *Euthanasia in the Netherlands* (1991) 2 (hereafter referred to as the Royal Dutch Medical Association, *Euthanasia in the Netherlands*).

⁹ Royal Dutch Medical Association, *Vision on Euthanasia*, 4-5. In so defining euthanasia, the Royal Dutch Medical Association has rejected the notion of 'passive' euthanasia.

The Dutch Penal Code

The starting point for analysis of the legal position in the Netherlands with regard to active voluntary euthanasia is Article 293 of the Dutch *Penal Code* 1886. It provides that:

A person who takes the life of another at that other person's express and serious request is punishable by imprisonment for a maximum of 12 years or by a fine.¹⁰

Article 293 of the Dutch *Penal Code* is the Article most frequently applicable in cases of active voluntary euthanasia.¹¹ It was introduced in 1886 to leave no doubt that the killing of a person is unlawful even if that person requests death.¹² The inclusion of Article 293 also serves to decrease the maximum term of imprisonment from life-long imprisonment as provided for murder¹³ to 12 years by virtue of the request of the victim. The rationale behind this diminished punishment is the fact that murder violates the life of a particular person whereas killing on request is a violation of the respect which is due to human life in general even though the personal right to life is not violated.¹⁴

Another relevant provision of the Dutch *Penal Code* 1886 is Article 40 which contains a defence of *force majeure* or 'necessity'. It provides that a person committing an offence under *force majeure* is not criminally liable.¹⁵ In the medical context, Article 40 has given rise to a particular defence known as *noodtoestand* or 'emergency' in which the defendant faces an irreconcilable conflict of duties.¹⁶ The recognition of the *noodtoestand* defence has played a central role in the development of Dutch jurisprudence with regard to euthanasia and has ultimately provided a means by which doctors in the Netherlands can perform active voluntary euthanasia without incurring criminal liability notwithstanding the prohibition in Article 293.

Jurisprudential Developments

Although active voluntary euthanasia is a punishable offence under Article 293 of the Dutch *Penal Code* 1886, the Dutch courts,¹⁷ through a series of decisions, have developed certain exceptions to

¹⁰ Keown, 51-52.

¹¹ Note also Article 294 dealing with assisted suicide which provides: A person who intentionally incites another to commit suicide, assists in the suicide of another, or procures the means to commit suicide is punishable, where death ensues, by imprisonment for up to three years or by a fine. See Keown, 52.

¹² Sluyters, 35.

¹³ See Article 289.

¹⁴ See M. Driesse *et al.*, 'Euthanasia and the Law in the Netherlands' (1988) 4 *Issues Law & Med.* 385, 387, referring to the Explanatory Memorandum for the Dutch *Penal Code* and H. J. Schmidt, *Geschiedenis van het Wetboek van Strafrecht* (History of the *Penal Code* of 1881), Vol II, 440.

¹⁵ Sluyters, 37.

¹⁶ See further discussion below, 361-367.

¹⁷ Comprising the District Courts, the Court of Appeal and the Supreme Court.

this prohibition by defining guidelines for the practice of active voluntary euthanasia. If these guidelines are observed, doctors will not incur liability. Essentially, the position is that a doctor can be acquitted, or, if found guilty, released with minimal punishment, and generally will not even be prosecuted, if the act of voluntary euthanasia took place in circumstances creating a conflict of duties for the doctor which constituted a higher necessity. These guidelines, initially developed by the courts, have subsequently been sanctioned by the Dutch medical profession, through prosecution guidelines, government commission statements and hospital protocols.

The first reported case of a Dutch doctor being prosecuted for having administered active voluntary euthanasia came before the Leeuwarden District Court in 1973.¹⁸ This case involved a doctor, Dr Geertruida Postma, who was prosecuted for ending the life of her mother. Dr Postma's mother had suffered a cerebral haemorrhage, was partially paralysed, had trouble speaking, and was deaf. She had unsuccessfully tried to commit suicide and had repeatedly expressed the wish to die.¹⁹ In response to her mother's request, Dr Postma killed her mother by injecting her with a fatal dose of morphine. Dr Postma readily admitted what she had done and said that her only regret was that she had not acted earlier.²⁰ At the time of the trial, quite a number of doctors had signed an open letter to the Dutch Minister of Justice stating that they had committed the same offence at least once.²¹ Dr Postma was convicted for contravention of Article 293 of the Dutch *Penal Code* 1886 but, because of her purity of motives, was only sentenced to a symbolic and conditional punishment.²² The Leeuwarden Court did, however, indicate that active voluntary euthanasia would have been acceptable if it were performed in circumstances where the patient is incurably ill, experiencing unbearable suffering, and requests the termination of his or her life and provided that the termination is performed by the doctor treating the patient or in consultation with him or her.²³

Whilst there have been some differences in the interpretation of this case,²⁴ the decision attracted widespread interest and public debate on the subject of active voluntary euthanasia and was soon hailed

¹⁸ *The Postma Case, Nederlands Jurisprudentie*, 1973, No. 183, District Court of Leeuwarden, 21 February 1973. See Note, 'Euthanasia Case Leeuwarden - 1973' (1988) 3 *Issues Law & Med.* 439. It should be noted that in 1952 the Utrecht Court convicted a doctor who had killed his severely suffering brother. However, the Leeuwarden case is generally cited as the first euthanasia case in the Netherlands, because the court in the earlier Utrecht decision did not consider issues relevant to the acceptability of euthanasia; Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 200 n. 7.

¹⁹ D. Humphry and A. Wickett, *The Right to Die* (1987) 180-181.

²⁰ L. Kennedy, *Euthanasia* (1990) 33.

²¹ Kuhse, 'Voluntary Euthanasia in the Netherlands,' 94.

²² She was given a suspended sentence of one week in gaol and one year probation. See Note, 'Euthanasia Case Leeuwarden - 1973', 442; Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 200.

²³ See Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 200; Note, 'Euthanasia Case Leeuwarden - 1973,' 439-440.

²⁴ There was some discussion in this case regarding the medical practice of manipulating medications in order to alleviate the unbearable suffering of an incurably ill patient, even if that course of action would shorten the patient's life. Whilst accepting the prevailing medical standard as a guide, the court held that Dr Postma had deviated from that standard by bypassing the course of alleviation and opting instead for immediate termination of her mother's life; Note, 'Euthanasia Case Leeuwarden - 1973'. Against this background, some commentators have raised doubts as to the scope of the decision; whether it merely permitted the hastening of death as a side effect of relieving pain or whether it was in

as a legal precedent for the performance of active voluntary euthanasia as an exception to Article 293 of the *Penal Code* 1886.²⁵ During Dr Postma's trial, the people in her village had banded together in a show of support and shortly after the passing of sentence, the first Dutch Voluntary Euthanasia Society was formed (the Nederlandse Vereniging Voor Euthanasie).²⁶ The aim of this society was to bring about changes to Article 293 of the Dutch *Penal Code* 1886 so as to expressly permit active voluntary euthanasia performed by a doctor. At the same time, another organisation, the Foundation for Voluntary Euthanasia (Stichting Vrijwillige Euthanasie) was formed under the leadership of lawyer Dr van Till.²⁷ Unlike the pressure group tactics of the Voluntary Euthanasia Society, the foundation was a 'think tank' of academics who tried to find a way to make a 'good death' accessible for those who really needed it, but without endangering those who were undecided or unwilling to die. This group was not convinced that the *Penal Code* 1886 should be changed and believed that jurisprudence could adequately deal with the problem. The foundation sought to promote public discussion on the subject and released a number of publications which were later used by the courts in the development of guidelines for the practice of active voluntary euthanasia.²⁸ During this time opinion polls conducted in the Netherlands showed growing support for the practice.²⁹

Another important development which took place in 1973 in the wake of the Leeuwarden Court decision was the release of a provisional statement on active voluntary euthanasia by the Royal Dutch Medical Association.³⁰ In this statement, the Royal Dutch Medical Association softened its earlier opposition to active voluntary euthanasia³¹ and expressed the somewhat tentative view that:

Legally euthanasia should remain a crime, but that if a physician, after having considered all the aspects of the case, shortens the life of a patient who is incurably ill and in the process of dying, the court will have to judge whether there was a conflict of duties which could justify the act of the physician.³²

This statement contributed to the opening of wide public debate on active voluntary euthanasia in the Netherlands and was the beginning of significant interaction on the subject between the courts and the Royal Dutch Medical Association.³³ The notion of 'conflict of duties' referred to in the association's statement came to be the basis for the defence accepted by the courts for the performance of active voluntary euthanasia.

fact intended to provide guidelines under which a doctor could avoid punishment under Article 293. For discussion see Driesse *et al.* 654-656; Bostrom, 474.

25 I. van der Sluis, 'The Practice of Euthanasia in the Netherlands' (1989) 4 *Issues Law & Med.* 455, 458.

26 Humphry and Wickett, 181.

27 *Ibid.*

28 Verbal communication with Dr van Till, November 1991.

29 Leenen, 'Euthanasia in the Netherlands,' 1-2.

30 Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (K.N.M.G.).

31 See, for example, the Royal Dutch Medical Association 1959 booklet, *Medical Ethics* in which active euthanasia and assisted suicide are strongly rejected and strong emphasis is placed on the doctor's duty to preserve life as long as possible.

32 Royal Dutch Medical Association, *Provisional Statement on Euthanasia* (1973).

33 De Wachter, 3317.

Following the Leeuwarden Court decision, several other cases were brought before the lower courts in the Netherlands, including a case of assisted suicide which was brought before the Rotterdam Criminal Court in 1981.³⁴ Although this case involved a lay person³⁵ and was therefore distinguishable from the earlier Leeuwarden Court decision, the Rotterdam Criminal Court took the opportunity to lay down specific guidelines under which the practice of active voluntary euthanasia would not be a punishable offence. These guidelines represented a synthesis of earlier legal developments as well as reflecting developments within the medical profession and contributions made by the voluntary euthanasia organisations with regard to the public debate on the permissibility of active voluntary euthanasia.³⁶ In order for a doctor to escape liability:

- (i) There must be physical or mental suffering which the sufferer finds unbearable;
- (ii) The suffering and the desire to die must be lasting (i.e. not temporary);
- (iii) The decision to die must be the voluntary decision of an informed patient;
- (iv) The patient must have a correct and clear understanding of his or her condition and of other possibilities (the results of this and that treatment and of no treatment); he or she must be capable of weighing those options and must have done so;
- (v) There is no other reasonable (i.e. acceptable for the patient) solution to improve the situation;
- (vi) The (time and manner of) death will not cause avoidable misery to others (i.e. the next of kin should be informed beforehand);
- (vii) The decision to give aid-in-dying is only open to medical doctors and should not be a one-person decision. Consulting another professional (medical doctor, psychologist, psychiatrist, social worker, according to the circumstances of the case) is obligatory;
- (viii) A medical doctor who is familiar with the relevant circumstances of the case must be involved in the decision and the prescription of the correct drugs; and
- (ix) The decision process and the actual aid must be done with the utmost care.³⁷

These conditions, sometimes referred to as the Leeuwarden and Rotterdam criteria,³⁸ also became the basis upon which decisions whether to prosecute were made.³⁹ The Public Prosecutor's Office in the Netherlands has the discretion not to proceed with a criminal case if it is considered to be in the public interest not to do so.⁴⁰ Following the decision of the Rotterdam Criminal Court, the Public Prosecutor's Office, in consultation with the Ministry of Justice, decided upon central co-ordination of cases of active voluntary euthanasia. Prosecution policy was adopted in conformity with the

³⁴ 1st December 1981. See Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 200.

³⁵ In this case, a woman was convicted and sentenced to six months conditional confinement for having provided the means and assisted in the suicide of an old lady who believed she had cancer.

³⁶ Written communication with Dr van Till, 1990.

³⁷ Humphry and Wickett, 186-187.

³⁸ Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 200.

³⁹ *Ibid.*

⁴⁰ E. Sutorius, 'How Euthanasia was Legalised in Holland,' paper delivered in Arnhem, the Netherlands (1985) 10.

guidelines established in the cases. A committee consisting of the country's five Chief Prosecutors (each of whom is attached to one of the five regional Courts of Appeal⁴¹) was formed to centrally review all euthanasia cases brought to the attention of the public prosecutor, and guidelines were issued by the government that no cases of medically administered active voluntary euthanasia were to be prosecuted before they had been examined by the committee and approved for prosecution.⁴²

However, even after the development of these guidelines by the courts and the decision of the prosecution to bring their policy into conformity with those guidelines, considerable uncertainty remained. There was no guarantee that a doctor who performed active voluntary euthanasia in accordance with the guidelines would not be prosecuted. Moreover, doubt remained whether decisions taken by the lower courts to accept active voluntary euthanasia under certain conditions, notwithstanding the prohibition in Article 293, would be upheld in the higher courts.⁴³

The *Alkmaar* Case 1984⁴⁴

The *Alkmaar* case was the first case to be brought before the Dutch Supreme Court and thus became a test-case for the permissibility of active voluntary euthanasia performed in accordance with the criteria laid down in the earlier decisions. This case also presented the opportunity for the Court of Appeal and the Supreme Court to consider and authoritatively pronounce upon various defences which had been advanced in the lower courts since the 1970s on behalf of doctors who had been prosecuted for the performance of active voluntary euthanasia.⁴⁵

A number of different defences have been put forward. One such defence is the 'medical exception' to the effect that a doctor who acts with due care and within generally accepted medical standards should not be convicted under Article 293 of the *Penal Code* 1886.⁴⁶ According to a number of jurists who have vigorously put forward this viewpoint, active voluntary euthanasia and assisted suicide should be considered a normal part of the services which doctors provide to their patients.⁴⁷ Another defence, also based on the interpretation of Article 293, is that the prohibition contained in this Article was not intended by the framers of the Code to cover the act of a physician in ending life.⁴⁸

A further defence which has been advanced is based on the argument that although the *terms* of a certain legal provision may prohibit a certain act, that act may not violate the *spirit* of the legal provision.⁴⁹ This defence is also sometimes expressed in terms of 'absence of material illegality'. The origins of this defence date back to a 1933 case in which it was held that a clear legal prohibition

⁴¹ C. Gomez, *Regulating Death* (1991) 60.

⁴² Sluyters, 41.

⁴³ See, for example, the concern expressed by the Royal Dutch Medical Association; de Wachter, 3318. See also Leenen, 'Supreme Court's Decisions on Euthanasia in the Netherlands,' 349.

⁴⁴ *Alkmaar Case*, *Nederlands Jurisprudentie* 1985, No.106, Supreme Court, 27 Nov. 1984.

⁴⁵ Sluyters, 36-38.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ Verbal communication with Professor Leenen and Dr Sutorius, November/December 1991.

⁴⁹ Sluyters, 37.

against subjecting healthy cattle to infectious disease did not apply to a veterinary surgeon because the infection caused was aimed at improving and not injuring the health of the animals.⁵⁰

Another defence which has been put forward by defence attorneys and in Dutch legal literature is the defence of *force majeure* or necessity which derives from Article 40 of the *Penal Code* 1886. In the context of medically administered active voluntary euthanasia this has taken the form of the *noodtoestand* defence which is essentially based upon an irreconcilable conflict of duties. According to this defence, the duty of a doctor to abide by the law and to respect the life of the patient may be outweighed by the doctor's other duty to help a patient who is suffering unbearably and for whom, to end this suffering, there is no alternative but death.⁵¹

The facts of the *Alkmaar* case were that the defendant, Dr Schoonheim, had given a series of lethal injections to his patient, a 95 year old woman, Maria Barendregt, who was seriously ill and who had no prospect of improvement. Some years earlier, the patient had discussed her deteriorating condition with her doctor and had signed an advance declaration stating that she requested active euthanasia if she were to be in such a condition that no recovery to a reasonable and dignified state of life was to be expected. At age 94 she fractured her hip, suffered hearing and vision loss, and at times was unable to speak or articulate. The weekend before her death, her condition deteriorated considerably. She was unable to drink or eat and became unconscious. She regained consciousness some days later and declared that she did not want to live through a similar experience. The defendant subsequently discussed the matter with his assistant doctor and with the patient's son, both of whom approved of performing active voluntary euthanasia upon the patient. After a final conversation with the patient later that week, in which she again declared her wish to die, the doctor decided to meet her request because, according to his judgement, every day that she lived would be a heavy burden for her with unbearable suffering.⁵² Dr Schoonheim then wrote on the death certificate 'unnatural death' and informed the police of his actions.

At first instance, before the Alkmaar District Court, the doctor was acquitted on the grounds of absence of material illegality.⁵³ The court found that although he had contravened the terms of Article 293 of the *Penal Code* 1886, his conduct, judged from a legal point of view, could not be termed undesirable. The court's acceptance of this defence was, to a large extent, based upon its willingness to recognise the principle of self-determination. The court stated that the principle of self-determination has been so generally accepted that it should prevail in an active voluntary euthanasia situation where the aid of a doctor is necessary to terminate life in a way worthy of a human being and without violence.⁵⁴ The court found that Dr Schoonheim had acted with the greatest possible care, giving serious consideration to the persistent suffering of his patient before taking the decision

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² Gevers, 159.

⁵³ H. Scholten, 'Justification of Active Euthanasia' (1986) 5 *Med. & Law* 169.

⁵⁴ Sluyters, 37; Scholten, 170.

to perform active voluntary euthanasia. It was held that since he had satisfied the highest standards of conscientiousness, his actions were not legally undesirable and therefore not materially illegal under Article 293. This was the first time that a lower court had actually acquitted a doctor who had performed active voluntary euthanasia.⁵⁵

The prosecution appealed to the Amsterdam Court of Appeal. The Amsterdam Court of Appeal overturned the decision, rejecting outright the doctrine of absence of material illegality.⁵⁶ The court held that while the doctor's actions might have been desirable, especially in terms of the patient's right to self-determination, such actions were still illegal, and the doctor was therefore still accountable under Article 293.⁵⁷ The defence counsel had, *inter alia*, relied on the notion of *noodtoestand* or emergency. This was presented on the grounds that the doctor had been faced with conflicting duties, and that after carefully weighing the conflicting duties and interests, in conformity with the standards of medical ethics and expertise, he had made a decision which was objectively justified.⁵⁸ However, the Court of Appeal rejected this argument.⁵⁹ The court was also critical of the fact that the doctor had relied solely on approval from the patient's son and the assistant doctor. In the opinion of the Court of Appeal, these two people were not sufficiently objective and independent.⁶⁰ Thus, the Amsterdam Court of Appeal found the doctor guilty. However, no punishment was imposed on the grounds that although it was doubtful that Dr Schoonheim had acted out of necessity, it was nonetheless evident that he had acted with integrity and due caution.⁶¹

The doctor appealed to the Dutch Supreme Court, the highest legal forum in the Netherlands. The Supreme Court affirmed the Court of Appeal's analysis as to the absence of material illegality⁶² but held that the court had wrongly rejected the defence counsel's plea that a conflict of duties caused the doctor to act under *force majeure* in an emergency situation (i.e. the *noodtoestand* defence).⁶³ The Supreme Court ruled that the a doctor's duty to abide by the law and to respect the life of the patient 'may be outweighed by his other duty to help a patient who is suffering unbearably, who depends upon him and for whom, to end his suffering, there is no alternative but death'.⁶⁴ The Supreme Court found that the Court of Appeal had failed to adequately investigate whether, according to responsible medical judgment, tested by norms of medical ethics, *force majeure* existed in this case as the doctor

⁵⁵ Humphry and Wickett, 187.

⁵⁶ H. Feber, 'De Wederwaardigheden van Artikel 293 van het Wetboek van Strafrecht Vanaf 1981 Tot Heden' ('The Vicissitudes of Article 293 of the *Penal Code* to the Present') in G. van der Wal, (ed.) *Euthanasie Knelpunten in een Discussie (Euthanasia: Bottlenecks in a Discussion)* 54-81 (1987), reviewed in Abstracts, (1988) 3 *Issues Law & Med.* 455, 456-457.

⁵⁷ D. Wainey, 'Active Voluntary Euthanasia: The Ultimate Act of Care for the Dying' (1989) 37 *Clev.St.L.Rev.* 645, 658.

⁵⁸ Sutorius, 6.

⁵⁹ Scholten, 170.

⁶⁰ *Ibid.*

⁶¹ Feber, 456.

⁶² Wainey, 658.

⁶³ E. Sutorius, 'A Mild Death for Paragraph 293 of the Netherlands Criminal Code?', paper delivered in Arnhem, the Netherlands (1985).

⁶⁴ D. Brahm, 'Euthanasia in the Netherlands' (1990) 58 *Medico-Legal J.* 98

had claimed.⁶⁵ According to the Supreme Court, the Court of Appeal could for instance have attached importance to:

- whether, and if so to what extent, according to professional medical judgment, increasing disfigurement of the patient's personality and/or increasing deterioration of her already unbearable suffering were to be expected;
- whether, also taking into account the possibility of new serious relapses, it was to be expected that soon she would no longer be in a position to die with dignity;
- whether, and if so to what extent, there had been ways to alleviate her suffering.⁶⁶

Because the Amsterdam Court of Appeal had not adequately investigated the conflict of duties for the doctor, its decision was reversed and the case was referred to the Court of Appeal of the Hague for final determination, with instructions to review the questions which had not been addressed in the lower court.⁶⁷ The Hague Court of Appeal upheld the reasoning of the Supreme Court and acquitted the doctor. The court found that although there was no medical consensus as to the permissibility of active voluntary euthanasia, the doctor's actions were 'justified according to *reasonable* medical insight'.⁶⁸ In reaching this decision, the court had relied heavily on the opinion of the Royal Dutch Medical Association with regard to active voluntary euthanasia which had been specifically sought for the purposes of this case.⁶⁹

The decision of the Supreme Court in the *Alkmaar* case, and its endorsement by the Hague Court of Appeal, was a significant development in securing the legal acceptability of active euthanasia on request in the Netherlands.⁷⁰ It effectively upheld the *noodtoestand* defence which recognises that a doctor may be faced with conflicting duties: the duty to uphold the law of the land which prohibits the taking of life, and the duty to act in the best interests of the patient. Since doctors cannot always simultaneously satisfy both duties, they cannot be held criminally responsible when they do what their professional duty demands, namely putting the patient's interests first.⁷¹ Although decisions of the Supreme Court only relate to the particular case before the court, in practice, its rulings have a strong influence on the lower courts. By accepting the appeal to *force majeure* in the sense of

⁶⁵ Leenen, 'Supreme Court's Decisions on Euthanasia in the Netherlands,' 350.

⁶⁶ Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 200.

⁶⁷ *Id.* 201. The Supreme Court only has jurisdiction on matters of law. Where it finds that the lower court had not remained within the law, it refers the decision to one of the Courts of Appeal to review the case, having regard to all the facts and circumstances; Sutorius, 'How Euthanasia was Legalised in Holland', 7.

⁶⁸ Feber, 462. (Emphasis in the original). The only point of departure from the decision of the Supreme Court was the change from 'responsible medical insight' to 'reasonable medical insight'. See also Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 201.

⁶⁹ Gomez, 37-38.

⁷⁰ For example, Leenen, 'Supreme Court's Decisions on Euthanasia in the Netherlands,' 350.

⁷¹ H. Kuhse, 'Sanctity of Life and the Role of the Nurse' (1988) 18 *Aust. Nurses J.* 10, 11.

conflicting duties, the Supreme Court made an opening for acquittal (or other lenient treatment) in individual cases of doctors administering active voluntary euthanasia under certain conditions.⁷²

A significant aspect of the Supreme Court's decision was its reliance upon medical standards in determining the validity of a plea based upon a conflict of duties. According to the Supreme Court, the primary judgement as to the permissibility of active voluntary euthanasia rests with the medical profession.⁷³ The court specifically ruled that in deciding whether, on the basis of the facts of the case, the doctor should not be held liable because of the 'emergency' he or she faced, the court should take into consideration 'scientific medical views and medical ethical norms.'⁷⁴ It could therefore be argued that, to a limited extent at least, the Supreme Court has accepted the medical exception defence.⁷⁵ This is not to say, however, that the question of the permissibility of active voluntary euthanasia is solely a medical concern: whilst the view of the medical profession as to the permissibility of active voluntary euthanasia in any particular case is, in the judgment of the Supreme Court, clearly relevant, where there is any doubt, a plea based upon conflicting duties must ultimately be determined by reference to legal standards, as assessed by the courts.⁷⁶

Although the decision of the Supreme Court has been widely welcomed, having paved the way for the legal acceptability of active euthanasia performed at the patient's request, it has been criticised for its reference to medical ethics.⁷⁷ It has been argued that active voluntary euthanasia is not purely a medical act, subject only to medical ethics, and that in any event, no norms exist within the medical profession as to the permissibility of the practice.⁷⁸ A better view of the decision is that the Supreme Court has not entirely delegated the decision as to the permissibility of active voluntary euthanasia to the medical profession, but rather will refer to medical standards, in so far as they exist, in determining the validity of a defence plea based upon a conflict of duties.

Some consideration should also be given to the role of the principle of self-determination in the *Alkmaar* case. In this, as in earlier cases, the principal focus of the court has been on the position of the defendant doctor, and the issue of patient autonomy has only been dealt with indirectly. Although the principle of self-determination was not a specific basis of the Supreme Court's decision in the *Alkmaar* case, it does clearly play an important role in that the performance of active voluntary

⁷² Leenen, 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients,' 5. It is, however, possible that the court finds that the defendant had committed some other offence; e.g. falsification of the death certificate.

⁷³ Sutorius, 'How Euthanasia was Legalised in Holland,' 12; Sluyters, 38.

⁷⁴ Sluyters, 38. The relevance of medical considerations is also apparent from the Supreme Court's finding that the Court of Appeal had erred in not investigating 'whether, according to responsible medical judgment, tested by norms of medical ethics, *force majeure* existed in this case' and from the specific matters which the Supreme Court identified as being relevant for consideration and which it directed the Hague Court of Appeal to take into account. See above, 363.

⁷⁵ For explanation, see above, 360. See also Sluyters, 38; Sutorius, 'How Euthanasia was Legalised in Holland,' 14.

⁷⁶ Sutorius, 'How Euthanasia was Legalised in Holland,' 12.

⁷⁷ Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 201; Feber, 458.

⁷⁸ Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 201. See also Bostrom, 483.

euthanasia is conditional on the express and earnest request of the patient.⁷⁹ The importance of patient self-determination is also evident from the Supreme Court's interpretation of the criterion of 'dying with dignity'⁸⁰ as being dependent on the patient's own life perspective.⁸¹ The principle of self-determination is, however, tempered by other considerations and certainly does not entitle a patient to demand the performance of active voluntary euthanasia in all circumstances. In light of the *Alkmaar* case, the permissibility of the doctor's act depends on the existence of a true 'emergency' situation and is therefore limited to exceptional circumstances.⁸²

It should also be noted that whilst upholding the existence of the *noodtoestand* defence in cases of active voluntary euthanasia, the Supreme Court did not specify the necessary criteria for the performance of lawful euthanasia. This can, to a large extent, be explained by the fact that the role of the Supreme Court is to adjudicate on the law, and any consideration of factual issues must be referred back to another court.⁸³ One can, however, interpret the Supreme Court's decision as giving at least tacit recognition to the guidelines for the performance of active voluntary euthanasia developed by the lower courts in earlier cases.⁸⁴

Since the landmark *Alkmaar* case, and its unequivocal acceptance of the *noodtoestand* or emergency defence, a number of further cases involving doctors performing active voluntary euthanasia have come before the Dutch courts.⁸⁵ These cases have confirmed the existence of the *noodtoestand* defence and have examined the application of this defence in different factual circumstances.

In 1985, two cases of active voluntary euthanasia were decided by the lower courts in Rotterdam and the Hague.⁸⁶ In both cases, the courts accepted the argument based upon the *noodtoestand* or emergency defence; that the doctor had made a decision which could objectively be regarded as justified in light of the conflicting duties and interests which the doctor faced.⁸⁷ The case before the Hague Court involved the prosecution of Dr Pieter Admiraal, a leading practitioner of active voluntary euthanasia in the Netherlands. The patient in this case was a 34 year old woman suffering from

⁷⁹ J. Gevers, 'Euthanasia or Assisted Suicide and the Non-Terminally Ill', in O. Aycke and M. Smook, (eds.) *Right to Self-Determination* (1990) 65, 66.

⁸⁰ This was amongst the relevant considerations which could have been considered by the Court of Appeal, see above, 363.

⁸¹ Feber, 463.

⁸² Gevers, 'Euthanasia or Assisted Suicide and the Non-Terminally Ill', 67.

⁸³ Verbal communication with Professor Leenen, December 1991.

⁸⁴ *Ibid.*

⁸⁵ For a discussion of these cases, see Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 202; Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 521-523. There have also been a number of cases brought before the medical disciplinary courts.

⁸⁶ Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 160.

⁸⁷ Note, however, that in the Rotterdam case, the doctor was found guilty of completing a false death certificate. In a number of cases the courts have held that where a patient dies following the administration of active voluntary euthanasia, one cannot say that death occurred as a result of natural causes. The doctor is therefore required to enter a declaration of non-natural death. A doctor cannot rely on the plea of necessity or professional secrecy to escape liability for falsification of a death certificate: B. Bostrom and W. Lagerwey, 'Court of the Hague (Penal Chamber) April 2 1987' (1988) 3 *Issues Law & Med.* 451.

multiple sclerosis. The patient had been experiencing physical and mental suffering and had repeatedly requested assistance to die. Dr Admiraal had complied with the patient's request in accordance with the guidelines laid down by the courts. The Hague Court dismissed the case against Dr Admiraal,⁸⁸ thereby confirming the proposition which had been first accepted in the 1973 Leeuwarden case that the patient need not be in the terminal phase in order for a doctor to be able to rely on the *noodtoestand* defence.⁸⁹

There has also been a recent prosecution against a psychiatrist who had assisted one of his patients to commit suicide. The Rotterdam Court accepted that unbearable psychic suffering of a patient could be the basis for the application of the *noodtoestand* defence.⁹⁰

In a number of other cases the doctors were convicted because it had not been established beyond reasonable doubt that the patient had requested active euthanasia.⁹¹ There have also been a number of cases involving nurses and nursing assistants who have terminated the lives of patients.⁹² The courts have held that nurses and nursing assistants cannot invoke the defence of *noodtoestand* or emergency because they are not entitled to undertake acts which may endanger the life of a patient. Arguments based upon pressures of psychic stress have been rejected on the grounds that nurses should be able to cope with stressful conditions.

Evaluation of Dutch Case Law Developments

It is clear from the foregoing analysis that quite an extraordinary situation exists in the Netherlands: notwithstanding the seemingly absolute prohibition of active voluntary euthanasia in Article 293 of the *Penal Code* 1886, in certain circumstances of unbearable suffering of a patient, active voluntary euthanasia may be performed by a doctor with the acquiescence of the law. A major step in this development was the acceptance by the Supreme Court in the *Alkmaar* case that *noodtoestand* (or emergency) could be a defence in a prosecution for active voluntary euthanasia. Apart from this landmark decision, other cases have also contributed in setting criteria to be followed by doctors when administering active voluntary euthanasia.⁹³ In addition to the need for a true emergency situation (*noodtoestand*), certain minimum requirements have emerged from the cases: the voluntariness of the patient's request; the requirement that the patient must suffer unbearably (physically or mentally); that

⁸⁸ Feber, 465.

⁸⁹ A. Vervoorn, 'Voluntary Euthanasia in the Netherlands: Recent Developments' (1987) 6 *Bioethics News* 19, 24; Wainey, 662 n. 150.

⁹⁰ 24 January 1992. (Written communication with Professor Leenen, July 1992.)

⁹¹ Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 160; Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 202; Leenen, 'Dying With Dignity: Developments in the Field of Euthanasia in the Netherlands,' 521-522.

⁹² Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 522.

⁹³ See also Leenen, 'Euthanasia in the Netherlands,' 1.

there must be no other way to relieve the patient's suffering; that only a doctor may perform active voluntary euthanasia; and that in doing so, he or she must consult with another doctor.⁹⁴

Significantly, the guidelines which have been developed by the Dutch courts regarding the circumstances under which the performance of active voluntary euthanasia is tolerated (sometimes also referred to as the 'carefulness requirements'), have subsequently been affirmed and extended by the Royal Dutch Medical Association, the State Commission on Euthanasia and the prosecution authorities.⁹⁵

Position of the Royal Dutch Medical Association

In 1984, the Central Committee of the Royal Dutch Medical Association issued a report outlining its official standpoint on active euthanasia, revising the association's provisional view formulated in 1973.⁹⁶ The need for publishing a statement of its views at this time had in part been precipitated by a request from the State Commission on Euthanasia, so that the commission could incorporate the association's views in its own work.⁹⁷ The association's 1984 statement reflected the significant social and legal developments which had taken place in the Netherlands since the release of its provisional statement in 1973.⁹⁸ The object of the 1984 report was not to argue the permissibility of active voluntary euthanasia, but rather, on the assumption that it was already being performed, to provide guidance as to the appropriate conditions under which it is performed and to draw attention to the legal uncertainty which existed at that time with regard to the practice of active voluntary euthanasia, both for doctors and patients.⁹⁹

The conditions for the performance of active voluntary euthanasia recommended by the Royal Dutch Medical Association Central Committee followed quite closely the guidelines laid down in the court decisions. A strong recommendation made by the association was that the practice of active voluntary euthanasia must be confined exclusively to the doctor/patient relationship.¹⁰⁰ This was not only

⁹⁴ Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands', 523. Leenen notes (n. 16) that the Supreme Court and a lower court left open whether, under certain conditions, not consulting another doctor would automatically result in conviction. It appears that the failure to consult a colleague would not necessarily prevent a doctor from bringing a successful plea of *noodtoestand*.

Although most of the cases have included consultation as one of the key requirements there is still no consensus as to the precise content of this requirement, (e.g. whether a doctor must consult with a doctor independent of the consulting doctor and the patient) and what form that consultation should take (e.g. whether the doctor who is consulted must see the patient in person.) (Verbal communication with Professor Leenen, Dr Sutorius, Dr Gevers and Chief Prosecutor Jitta, November/December 1991.)

⁹⁵ Rigter, Borst-Eilers and Leenen, 1594.

⁹⁶ Royal Dutch Medical Association, Central Committee, *Vision on Euthanasia* (English translation and adaption of an article first published in Dutch in the Royal Dutch Medical Association official magazine, August 1984.) See above, 358 for reference to the 1973 statement.

⁹⁷ Royal Dutch Medical Association, *Vision on Euthanasia*, 3. For discussion of the State Committee on Euthanasia see below, 372-374.

⁹⁸ Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 158.

⁹⁹ Royal Dutch Medical Association, *Vision on Euthanasia*, 3.

¹⁰⁰ *Id.* 7.

because the practice requires medical and pharmacological expertise, but also because only doctors were in a position to give a diagnosis and prognosis of the patient's condition. Moreover, doctors are accountable for their conduct under the medical code of ethics and can be brought before a disciplinary court in the event that they breach the rules. It was accordingly recommended that the medical profession has an obligation to come up with a socially acceptable approach for the practice of active voluntary euthanasia. It was further recommended that the practice of active euthanasia at the patient's request by a doctor must be completely voluntary.¹⁰¹ A doctor who is opposed to the practice is, however, required to enable the patient to come into contact with another doctor who is willing to assist, but without necessarily breaking off his or her own relationship with the patient.¹⁰² In view of the irrevocable and exceptional character of active voluntary euthanasia, doctors who are willing to perform the practice will have to meet a number of conditions and active voluntary euthanasia should only be performed as a last resort. Taking into account jurisprudential developments in the Netherlands with regard to the administration of active voluntary euthanasia, it was recommended that doctors will have to meet the following requirements with regard to the exercise of due care:

- (i) that the request for euthanasia is entirely voluntary;
- (ii) that it is a well considered request;
- (iii) without indicating any particular time span, that the request for euthanasia is a durable wish;
- (iv) that the patient is experiencing unacceptable suffering, be it suffering due to pain, whether or not based on a perceivable physical condition or suffering due to a physical condition or physical disintegration without pain; and
- (v) consultation with a colleague with experience in the field.¹⁰³

The central committee was of the view that one should not ascribe an overriding importance to whether or not the patient is in the dying phase. This represented a change from the associations' provisional view formulated in 1973,¹⁰⁴ reflecting case law developments in which the courts have not insisted on this being a requirement. According to the central committee, the key question is whether a situation has been reached in which the patient voluntarily expresses a wish for death in a well-founded way and the doctor acknowledges the patient's unacceptable suffering, and that the suffering may be considered prospectless.¹⁰⁵ It was, however, recommended that there should be a stipulation to the effect that active voluntary euthanasia be performed in a manner that is medically and pharmacologically justified.¹⁰⁶

¹⁰¹ *Id.* 7-8.

¹⁰² *Id.* 8.

¹⁰³ *Id.* 8-11. For analysis of these criteria see Gomez, 40-42.

¹⁰⁴ See above, 358.

¹⁰⁵ Royal Dutch Medical Association, *Vision on Euthanasia*, 12.

¹⁰⁶ *Id.* 16.

In the interests of a balanced decision-making process, the central committee was of the view that consultation within professional medical circles is indispensable.¹⁰⁷ It recommended that in addition to informal consultation within the doctor's own team, there should be a more formal evaluation procedure to judge the merits of the request for active euthanasia by way of a committee of medical examiners consisting, for example, of a number of doctors to be appointed regionally by the Royal Dutch Medical Association.¹⁰⁸

With regard to the reporting procedure after active voluntary euthanasia has been performed, the central committee acknowledged that it is not unusual for doctors to record cases of active voluntary euthanasia as 'natural deaths' in order to protect the next of kin and/or to protect themselves from the unpleasant consequences attached to legal proceedings, even if no punishment is ultimately imposed.¹⁰⁹ The committee was of the view that this practice was inappropriate, simply obscuring the tension which exists between the strict legal position as reflected in Article 293 of the *Penal Code* 1886 and the practice of active voluntary euthanasia. Moreover, it has the consequence that the actual practice with regard to active voluntary euthanasia is absolutely unverifiable. It was accordingly recommended that doctors exercise due openness in reporting the cause of death. By the same token, however, it was thought that a doctor who complies with the conditions for the exercise of due care in the performance of active voluntary euthanasia may reasonably expect not to be prosecuted. In order to unequivocally achieve this end, greater clarity was called for and the committee recommended a modification of the legislation on the disposal of the dead as well as clear arrangements being made between the Ministry of Justice and the Royal Dutch Medical Association with regard to prosecution policy concerning the performance of active voluntary euthanasia by doctors until such time that legislation is introduced.¹¹⁰

Whilst the central committee had expressed its concern about the legal uncertainty concerning active voluntary euthanasia both for doctors and patients, and had strongly urged that this uncertainty be eliminated as soon as possible,¹¹¹ the association refrained from saying whether the introduction of legislation was the appropriate solution.¹¹² What was important was that there should be legal security for doctors and patients, whether this was achieved through explicit guidelines for prosecution developed by jurisprudence or by legislation.¹¹³

Since the release of the 1984 revised statement on active voluntary euthanasia by the Royal Dutch Medical Association, the association has been involved in a number of other initiatives. In 1987, the

¹⁰⁷ *Id.* 11, 12-13.

¹⁰⁸ The specifics of this recommendation were not in the English translation of the central committee's vision, but appear in various other summaries and accounts, see, for example, Sutorius, 'How Euthanasia was Legalised in Holland,' 15.

¹⁰⁹ Royal Dutch Medical Association, *Vision on Euthanasia*, 14.

¹¹⁰ *Id.* 15.

¹¹¹ *Id.* 1.

¹¹² Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 159.

¹¹³ M.G. van Berkestijn, 'The Royal Dutch Medical Association and the Practice of Euthanasia and Assisted Suicide,' in Royal Dutch Medical Association, *Euthanasia in the Netherlands*, 6.

Royal Dutch Medical Association and the Dutch nurses' union issued a joint paper which laid down practical guidelines for health care professionals participating in the active voluntary euthanasia decision.¹¹⁴ As with the association's 1984 statement on active voluntary euthanasia, this joint paper does not attempt to evaluate the permissibility of active voluntary euthanasia, but rather, to provide practical guidelines with regard to the respective tasks, competences and responsibilities of both doctors and nurses with regard to the performance of active voluntary euthanasia. These guidelines are intended not only to protect the legal position of doctors and nurses but also to protect the legal rights and interests of patients by sanctioning only voluntary euthanasia and requiring documentation of the decision-making process.¹¹⁵

It is made clear under the guidelines that the decision-making process for active voluntary euthanasia occurs under the final responsibility of a doctor. The doctor must satisfy him or herself of the voluntariness of the patient's request, that it is a well considered and persistent request, and that the patient is experiencing unacceptable suffering. Furthermore, the doctor must consult with at least one colleague about the request of the patient.¹¹⁶ The guidelines also recognise the central role of nurses in the care of patients and that in some cases, the request for active euthanasia may initially be made to the nursing staff.¹¹⁷ The guidelines emphasise the need for open dialogue between doctors and nurses and for joint participation in the decision-making process.¹¹⁸ However, the guidelines recommend that the ultimate decision of whether or not to proceed with active voluntary euthanasia must be taken by the doctor.¹¹⁹ With regard to the performance of active voluntary euthanasia, the guidelines recognise that only doctors have the protection of the law and that a nurse who independently engages in active voluntary euthanasia, even if she observes the procedure for appropriate medical care, would almost certainly be prosecuted.¹²⁰ It was accordingly recommended that the act of euthanasia be performed by the doctor alone. However, where this is not possible, (where, for example, a procedure is chosen at the request of the patient, involving a number of activities which the doctor cannot carry out alone) the doctor can ask a nursing or caring attendant who was involved in the decision-making process to co-operate in the procedure.¹²¹ If the nursing or caring attendant is convinced that all the criteria of appropriate medical care have been met and, in accordance with his or her conscience, agrees to co-operate, a written agreement must be entered into between the doctor and nurse/caring attendant with regard to the carrying out of the procedure, specifying who performs which action and when.¹²² The joint guidelines also stress the desirability

¹¹⁴ For an English translation of the guidelines, see Note, 'Guidelines for Euthanasia' (1988) 3 *Issues Law & Med.* 429.

¹¹⁵ *Wainey*, 664.

¹¹⁶ 'Guidelines for Euthanasia,' 431-433.

¹¹⁷ *Id.* 433.

¹¹⁸ *Id.* 433-434.

¹¹⁹ *Id.* 434.

¹²⁰ *Id.* 436.

¹²¹ *Id.* 435.

¹²² *Ibid.*

of developing procedural agreements for each work organisation with regard to the carrying out of active voluntary euthanasia.¹²³

Consideration has so far focused on the position of the Royal Dutch Medical Association and the main Dutch nursing organisation with regard to the practice of active voluntary euthanasia. In order to present a complete picture, it should also be noted that there is some opposition to the practice of active voluntary euthanasia from within the Dutch medical profession. There are a number of medical organisations including the Nederlands Artsenverbond (Dutch League of Physicians) and the Pro Life Doctors which are officially opposed to the practice. Some Dutch doctors are also members of the World Federation of Doctors who Respect Human Life, an international organisation which is actively campaigning against the legalisation of active voluntary euthanasia in the Netherlands.¹²⁴ There are also many doctors who, although not in principle opposed to active voluntary euthanasia, refuse to practice it while it is still illegal.¹²⁵ Significantly though, the endorsement of active voluntary euthanasia by the Royal Dutch Medical Association in its 1984 statement resulted in very few cancellations of membership. Of a total of 30,000 Dutch doctors, 25,000 are members of the Royal Dutch Medical Association. This provides some grounds for suggesting that the vast majority of Dutch doctors are not opposed to active voluntary euthanasia, provided it is confined to the strict conditions that have been advocated by the central committee of the Royal Dutch Medical Association.¹²⁶

Institutional Policies and Procedures

As the practice of active voluntary euthanasia remains punishable, individual doctors, hospitals and health care institutions have attempted to protect themselves by following policies that will prevent a prosecution from being initiated. To this end, many hospitals and nursing homes have developed their own institutional guidelines and prescribed their own procedures for the practice of active voluntary euthanasia.¹²⁷ It is estimated that 80% of all institutions of the health services have a euthanasia protocol or directive.¹²⁸ Almost all of them leave some room for active voluntary euthanasia, usually under very strict conditions and review, and they also compel the doctor to report the occurrence of active voluntary euthanasia.¹²⁹ Information is readily available to doctors in the Netherlands regarding how to perform active euthanasia.¹³⁰

¹²³ *Ibid.*

¹²⁴ *News Exchange of the World Federation of Doctors who Respect Human Life* 'Euthanasia in Holland' Part I No. 97, October 1987 and Part II No. 99, April 1988.

¹²⁵ Kennedy, 38.

¹²⁶ Van Berkestijn, 8.

¹²⁷ De Wachter, 3318-3319.

¹²⁸ Van Berkestijn, 9.

¹²⁹ *Ibid.*

¹³⁰ See, for example, the publication by P. Admiraal, *Justifiable Euthanasia* (1980). Dr Pieter Admiraal, an anaesthesiologist practising for many years at the Delft General Hospital, was the first Dutch doctor to speak openly about his involvement with active voluntary euthanasia. Dr Admiraal has been a high profile campaigner for the acceptance of active voluntary euthanasia both within his own country and

The Netherlands State Commission on Euthanasia¹³¹

In response to calls for reform, a State Commission on Euthanasia was established in 1982 by Royal Decree. The role of this commission was to advise the government concerning its future policy with regard to active voluntary euthanasia and of rendering assistance in self-killing, in particular with respect to legislation and the application of the law. The commission comprised 15 members: 7 lawyers, 3 doctors, 2 psychiatrists, 1 nurse and 2 theologians.¹³² The report of the commission was released in August 1985 and its recommendations were set out in the form of a proposal for the amendment of the Dutch *Penal Code* 1886. By a majority of 13 to 2, the commission recommended that the present prohibition in the *Penal Code* 1886 should be revised so as to allow doctors to practise active voluntary euthanasia under conditions similar to those developed by the courts.¹³³ The commission was of the view that the intentional killing of another person at the latter's explicit and earnest request should remain punishable under Article 293 of the *Penal Code* 1886, but that an exception should be incorporated into the law for a doctor who does so with regard to a patient who is in an untenable situation without any acceptable prospects for change, and provided the act is carried out within the framework of careful medical practice.¹³⁴ It was recommended that assistance to suicide should be regarded within the same circumstances and on the same conditions as active voluntary euthanasia.¹³⁵ The commission went on to elaborate the minimum requirements for careful medical practice, including that:

- a) the patient has been informed of his or her particular circumstances;
- b) the doctor has satisfied him or herself that the patient has made his or her request for life to be terminated after careful consideration and voluntarily abides by that decision;
- c) the doctor has decided that terminating life on the basis of his or her findings would be justified, because he or she has reached the conclusion together with the patient, that there is no other acceptable solution to the patient's untenable situation; and
- d) the requirement of consultation with another medical practitioner nominated by the Minister of Welfare, Public Health and Culture.¹³⁶

abroad. He has written numerous articles, presented many papers, and has, for a number of years, been involved with the Dutch Voluntary Euthanasia Society (N.V.V.E.).

¹³¹ Note, 'Final Report of the Netherlands State Commission on Euthanasia: An English Summary' (1987) 1 *Bioethics* 163. (Hereafter referred to as the Report of the Netherlands State Commission on Euthanasia.)

¹³² De Wachter, 3317.

¹³³ Report of the Netherlands State Commission on Euthanasia. The report dealt with many issues including minors, incompetent adults, prisoners, conscientious objectors, the role of nurses and pharmacists, and the use of advance directives.

¹³⁴ Report of the Netherlands State Commission on Euthanasia, 167. Four members of the commission wanted to include the additional requirement that the patient's death be 'impending and inevitable'. See the report, 166.

¹³⁵ Report of the Netherlands State Commission on Euthanasia, 167.

¹³⁶ *Id.* 173.

In order to underline the importance of the request of the patient, the commission recommended the introduction of a new provision to the effect that a person who intentionally terminates the life of another person on account of serious physical or mental illnesses or disorders suffered by that person, if the latter is incapable of expressing his or her will, will be guilty of an offence.¹³⁷

The commission was of the opinion that a decision to terminate life should be implemented by a doctor and cannot be delegated to a third party, for example, a member of the family or nursing staff.¹³⁸ In order to demonstrate the importance of the requirement that a doctor must consult another doctor before terminating the life of a patient (included amongst the commission's criteria for careful medical practice), the commission recommended the introduction of a separate punitive sanction to cover any case where the doctor omits to take this step.¹³⁹ The commission also recommended the inclusion in any new legislation of a 'conscience clause' to the effect that no medical worker should be obliged to participate in the active termination of life of a patient.¹⁴⁰ The commission also set out procedures with regard to body disposal and for the notification of the prosecution by a doctor following the termination of the life of a patient.¹⁴¹ It was recommended that body disposal procedures should be designed in such a way as to permit retrospective verification of the way in which the decision to terminate life was taken.¹⁴² The commission recommended that the doctor in charge personally notify the public prosecutor that he or she had terminated the patient's life or assisted the patient to take his or her own life.¹⁴³ Such notification should be accompanied by a statement of the way in which the criteria proposed for the *Penal Code* 1886 had been taken into account.¹⁴⁴ The public prosecutor should also be sent a declaration setting out the findings of the doctor consulted by the doctor in charge.¹⁴⁵ It was also recommended that the doctor in charge must notify the occurrence of active voluntary euthanasia on the cause of death form.¹⁴⁶ Further, it was recommended that the deliberate failure to fulfil the statutory requirement to furnish particulars with regard to death, or the provision of incorrect particulars in cases where life has been terminated, should be made a separate offence.¹⁴⁷

¹³⁷ See Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 204; Report of the Netherlands State Commission on Euthanasia, 172. The commission did, however, express the view that the intentional termination of the life of a person unable to express his or her will should not be an offence provided that this is performed by a doctor in the context of careful medical procedure in respect of a patient who, according to the current state of medical knowledge, has irreversibly lost consciousness, and provided also that treatment has been suspended as pointless; Report of the Netherlands State Commission on Euthanasia, 168. This proposal was not included in the legislative reforms recommended by the commission.

¹³⁸ Report of the Netherlands State Commission on Euthanasia, 168.

¹³⁹ *Id.* 173.

¹⁴⁰ De Wachter, 3318.

¹⁴¹ Report of the Netherlands State Commission on Euthanasia, 170.

¹⁴² *Ibid.*

¹⁴³ *Ibid.*

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ *Id.* 173.

The commission also considered the status of written requests for the termination of life. It considered that a written request of this kind must be treated as an indication of the patient's wishes but should only carry authority when the patient is no longer able to make his or her will known.¹⁴⁸ As long as a patient is still competent, only his or her verbal expression of intent is relevant and the written instructions can be revoked or amended at any time.¹⁴⁹

In its report, the commission deemed it essential for parliament to make plain its position on active voluntary euthanasia.¹⁵⁰ The commission was particularly concerned that the issue could become politicised, and to this end, urged that a free vote be allowed on the question in which members of parliament could vote according to their own conscience.¹⁵¹ The commission was also concerned about the widespread uncertainty regarding the scope of Article 293 of the *Penal Code* 1886 in relation to active voluntary euthanasia.¹⁵² In the commission's view, the development of relevant case law would take so long that it would be many years before the exact definition emerges of what is and what is not an offence.¹⁵³ Nor, in the commission's view, does the modification of prosecution policy in accordance with case law developments, provide the necessary clarity and certainty.¹⁵⁴

Two members of the commission could not agree to the regulation of active voluntary euthanasia in the law and presented their objections in a minority report rejecting any change or modification to the present prohibition on killing on request.¹⁵⁵ The objections raised by the dissenters included the fear that if the Netherlands proceeded with the legalisation of active voluntary euthanasia, it could result in the isolation of the Netherlands from the international community, particularly through the possible contravention of Article 2 of the *Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms*.¹⁵⁶ The other main objections were based on the concept of human dignity and on 'slippery slope' arguments.¹⁵⁷

The report of the State Commission gave rise to an extensive, and often emotional debate in medical and legal journals and in the mass media.¹⁵⁸ It also precipitated critical discussion as to the need for legislation with regard to active voluntary euthanasia and if so, what form that legislation should take.

¹⁴⁸ *Id.* 166.

¹⁴⁹ *Ibid.*

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

¹⁵² *Id.* 167.

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*

¹⁵⁵ *Id.* 166.

¹⁵⁶ Vervoorn, 20-21.

¹⁵⁷ Roscam Abbing, 72.

¹⁵⁸ Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 160; G. Pence, 'Do Not Go Slowly into That Dark Night: Mercy Killing in Holland' (1988) 84 *American J. Med.* 139, 140; de Wachter, 3318.

Even prior to the release of the State Commission's report, a draft Bill for the legalisation of active voluntary euthanasia was introduced into the lower house of parliament by one of the smaller non-denominational political parties - D66. The Wessel-Tuinstra Bill (named after the member of parliament who introduced it) proposed the amendment of Article 293 of the *Penal Code* 1886 so as to legalise active voluntary euthanasia administered by a doctor in accordance with specified carefulness requirements.¹⁵⁹ It also made provision for the legal recognition of a patient's prior written request (in effect, an advance directive) as evidence of a patient's request for active euthanasia in circumstances where the patient is no longer competent. This Bill became the focal point for debate on the subject of active voluntary euthanasia both within and outside the government, but no action was taken on the Bill pending the report of the State Commission on Euthanasia. After the commission's report was published, the Bill was revised in accordance with the commission's recommendations.¹⁶⁰ Although the revised Bill had the support of a small majority in the parliament, it was opposed by the Christian Democrats who were in office together with the Conservative Party which supported the proposed legislation.¹⁶¹ This presented a political problem for the coalition government which the government attempted to solve by introducing its own, more restrictive, draft Bill in January 1986.¹⁶² In addition to the usual carefulness requirements, the government Bill contained an additional requirement that 'according to accepted medical understanding there is concrete expectation of death as a consequence of the illness or affliction and further medical treatment would serve no reasonable purpose'.¹⁶³ However, in a rather unusual step by the government, the draft Bill was introduced without being given the formal status of a proposed law. In a covering letter accompanying the Bill, the Minister of Justice and the Minister of Welfare, Health and Cultural Affairs, said that the government would prefer not to amend the law at this stage and would rather allow case law to develop in this area. It was indicated that in the event that the lower house was to take the view that it was desirable to enact legislation, the Ministers indicated that the specimen Bill would be revised and put to the State Council for its opinion.¹⁶⁴ At this point the Royal Dutch Medical Association, which was opposed to the government's 'draft Bill' on the grounds that it would create more uncertainties,¹⁶⁵ came down firmly in favour of legislative reform in accordance with jurisprudential

¹⁵⁹ Second Chamber of the States-General, Session 1985-1986, 18 331, No. 38.

¹⁶⁰ For an English translation of the revised Bill, see Vervoorn, 21-23.

¹⁶¹ Leenen, 'Dying with Dignity: Development in the Field of Euthanasia in the Netherlands,' 524.

¹⁶² *Ibid.*

¹⁶³ Vervoorn, 23. This is even more restrictive than case law developments in the Netherlands which have upheld the practice of active voluntary euthanasia in appropriate circumstances notwithstanding that the patient was not terminally ill. This Bill was also more restrictive with regard to the need to involve close relatives in the decision-making process and with regard to the performance of active euthanasia upon minors; Vervoorn, 24. It did, however, make provision for the legal recognition of an advance directive as evidence of a patient's request for active euthanasia.

¹⁶⁴ Driesse *et al.*, 395.

¹⁶⁵ For a detailed critique of the Government's draft Bill from the perspective of the medical profession see M.G. van Berkestijn, 'The Royal Dutch Medical Association Attitude Towards Euthanasia: With the Criterion 'Terminal Phase' Things Are Getting Out of Hand' in Royal Dutch Medical Association, *Euthanasia in the Netherlands* (translation of an article 'Met het Criterium 'Stervens Fase' is het Hek Van de Dam' (1986) 41 *Medisch Contact* 291-293.)

developments and the association's own viewpoint.¹⁶⁶ Parliamentary debate on both Bills took place in March 1986 during which the Conservative Party, as a result of pressure from the Christian Democrats, withdrew its support for the proposed legislation.¹⁶⁷ Following the parliamentary debate, both proposals were submitted to the State Council for its opinion. In the meantime, an election was held and the Conservative Party and the Christian Democrats coalition was restored to government. During the formation of the Cabinet, both parties agreed that the issue of active voluntary euthanasia must not lead to a breakdown of the coalition and that they would abide by the future advice of the State Council.¹⁶⁸

In July 1986, the State Council released its advice to the government. The State Council recommended against the immediate introduction of legislation and suggested that the body of case law be allowed to develop further before any legislative action was taken.¹⁶⁹ However, in view of the ongoing public debate on the subject and the earlier legislative proposal which was still pending in parliament, this recommendation was unacceptable to the government.¹⁷⁰ The government sought advice from the General Health Council¹⁷¹ and a compromise position was subsequently reached which differed from the recommendations of both the State Commission on Euthanasia and the State Council. The government's position, published in January 1987, recommended retention of the existing prohibition on active voluntary euthanasia, but that doctors could invoke *force majeure* (necessity) when certain requirements for careful medical practice and administrative rules were met which would be set out in the Act regulating the practice of medicine.¹⁷² These carefulness requirements were essentially to follow the proposal of the State Committee on Euthanasia.¹⁷³ This compromise reflected the position of the Christian Democrats that active voluntary euthanasia remain punishable, and at the same time, at the behest of the Conservatives, incorporating in the law the criteria for careful medical practice to be followed by a doctor performing active voluntary euthanasia.¹⁷⁴ This proposal was, however, subject to criticism on the grounds that it was a half-way measure, lacking legal coherence, and disregarding the opinion of the majority of the population which is in favour of immunity for a doctor who administers active voluntary euthanasia in accordance with the rules.¹⁷⁵ One prominent Dutch legal commentator, Professor Leenen, has suggested that the main problem with this compromise was that there was no connection between the proposed section of the *Medical Practice Act* 1865 and the *Penal Code* 1886; as a consequence, doctors

¹⁶⁶ Van Berkestijn, 'The Royal Dutch Medical Association and the Practice of Euthanasia and Assisted Suicide,' 7.

¹⁶⁷ Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 524.

¹⁶⁸ Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 161.

¹⁶⁹ *Ibid.*

¹⁷⁰ Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 524; Leenen, 'Euthanasia in the Netherlands,' 8.

¹⁷¹ See Wainey, 662; Bostrom, 472-3 for details of the General Health Council's *Proposal of Advice Concerning Carefulness Requirements in the Performance of Euthanasia* (1987).

¹⁷² *Medical Practice Act (Wet Uitoefening Geneeskunst)* 1865. See Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 205.

¹⁷³ Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 524.

¹⁷⁴ *Ibid.*

¹⁷⁵ See, for example, Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 524; Sluyters, 40; Roscam Abbing, 73.

who have performed active voluntary euthanasia and have followed the rules of careful medical practice remain punishable and can only invoke *force majeure*, to be assessed on a case by case basis by the prosecution and the courts.¹⁷⁶

During the course of 1987, the Dutch government commenced consultation within the framework of the Council of Europe in order to test the attitudes of other countries to the issue of active voluntary euthanasia.¹⁷⁷ In particular, it sought an opinion of the feasibility and desirability of the Council of Europe undertaking a study of the legal, human rights, ethical and medical problems relating to euthanasia. This was done in order to avoid the possibility that the Netherlands might end up in an internationally isolated position as a result of its stance with respect to active voluntary euthanasia. However, the Council of Europe Working Party which was required to consider this matter¹⁷⁸ reached the conclusion that such a study, even if feasible, was not desirable.¹⁷⁹

Notwithstanding this negative response from the Council of Europe, the government's compromise proposal led to the introduction of draft legislation in December 1987. Under this legislative proposal, Article 293 of the *Penal Code* 1886 was to remain unchanged except for a decrease of the maximum term of imprisonment from 12 years to 4 and 1/2 years.¹⁸⁰ Under separate legislation,¹⁸¹ an amendment was proposed to the effect that 'without prejudice to his or her responsibility under the *Penal Code* 1886, a medical doctor who wishes to follow the explicit serious wish of a patient to terminate the life of that patient should abide by a number of requirements of careful medical behaviour.' Those requirements, largely based on the recommendations of the State Commission, were also set out in the proposed legislation.¹⁸²

The critical feature of this proposal was that doctors would remain punishable for performing active voluntary euthanasia. In any particular case it would be left to the prosecution, and ultimately the courts, to decide whether the doctor had complied with the statutory requirements and if so, whether this would lead to the successful invocation of the *force majeure* defence.¹⁸³ Thus, it would simply give statutory effect to the current position in the Netherlands where *de facto* recognition of active voluntary euthanasia has been achieved through jurisprudential developments and prosecution policy. Debate on both this legislative proposal and the earlier Wessel-Tuinstra Bill proposing the

¹⁷⁶ Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 524; Sluyters, 40.

¹⁷⁷ See also chapter VII, 350-351.

¹⁷⁸ Working Party of the Ad Hoc Committee of Experts on Progress in Biomedical Science of the Council of Europe.

¹⁷⁹ See also chapter VII, 351.

¹⁸⁰ Sluyters, 40.

¹⁸¹ *Medical Practice Act* 1865.

¹⁸² See Roscam Abbing, 73 for details. The proposed legislation also seeks to clarify the meaning of euthanasia by specifying certain medical practices which would not fall within its scope; e.g. withdrawal of useless treatment, refusal of further treatment by the patient, and the administration of pain-relieving drugs which hasten death.

¹⁸³ Roscam Abbing, 73.

legalisation of active voluntary euthanasia, was due to proceed in April 1989 but did not take place because in the spring of 1989 the coalition government fell.¹⁸⁴

The new coalition government of Christian Democrats and Socialists was unable to reach agreement with regard to active voluntary euthanasia legislation. It was decided to postpone a decision until more reliable information was available about the practice of active voluntary euthanasia in the Netherlands.¹⁸⁵ In order to obtain this information, a committee was set up in February 1990 under the Chairmanship of Professor Rummelink, Procurator-General of the Dutch Supreme Court, to conduct a nation-wide survey amongst doctors.¹⁸⁶ In the meantime, both draft Bills remained pending in parliament.¹⁸⁷

The Rummelink Report

Background to the Report

Prior to the release of the results of the Rummelink Committee inquiry, which for the first time involved a comprehensive nation-wide survey, no precise figures have been available regarding the extent to which active voluntary euthanasia is being performed in the Netherlands.¹⁸⁸ This lack of accurate information has largely been attributable to the fact that many doctors are still reluctant to report cases of active voluntary euthanasia to the police as a result of fear of investigation and prosecution and/or the desire to protect the family of the deceased from this type of investigation.

After the death of a patient, the treating doctor may only issue a death certificate in cases of natural death.¹⁸⁹ Active voluntary euthanasia is not considered to be a natural death, and therefore a doctor cannot by law issue a death certificate. Indications were, however, that in the majority of cases of

¹⁸⁴ De Wachter, 3318.

¹⁸⁵ P. van der Maas *et al*, 'Euthanasia and Other Medical Decisions Concerning the End of Life' (1991) 338 *Lancet* 669 (hereafter referred to as van der Maas *et al*).

¹⁸⁶ *Ibid*.

¹⁸⁷ Leenen, 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients,' 9.

¹⁸⁸ There have been a number of smaller surveys conducted in the 1980's which indicated that there were approximately 2,000-3,000 cases of active euthanasia each year by general practitioners, comprising about 2% of all deaths occurring in general practice in the Netherlands; A. Oliemans and H. Nijhuis, 'Euthanasie in de Huisartspraktijk' (1986) 41 *Medisch Contact* 691, cited by Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 161-162; de Wachter, 3316 referring to F. van Wijmen, *Artsen en het Zelfgekozen Levenseinde*, Maastricht, the Netherlands: University of Limburg (1989); Note, 'Voluntary Euthanasia by Dutch General Practitioners' (1991) Vol. 10 No. 4 *Bioethics News* 4-5; H. Hellema, 'Dutch Euthanasia Overestimated' (1991) *B.M.J.* 870; E. Borst-Eilers, 'Facts About the Actual Euthanasia Practice in the Netherlands', in Royal Dutch Medical Association, *Euthanasia in the Netherlands*, 3-5, where she refers to a number of surveys (the 1986 Hague survey conducted by Oliemans and Nijhuis, the 1988 Amsterdam survey conducted by the Municipal Public Service, and the 1989 Continuous Morbidity Registration survey, published by Bartelds *et al*).

¹⁸⁹ Sluyters, 40.

active voluntary euthanasia, doctors were falsifying the death certificate and entering the death as one by natural causes.

As the practice of active voluntary euthanasia was gaining acceptance by the courts, a reporting procedure was established whereby a doctor who had performed active voluntary euthanasia was required to telephone the police to advise that he or she had done so.¹⁹⁰ Before a burial or cremation could proceed, permission had to be obtained from the prosecuting authorities.¹⁹¹ Upon the reporting of a case of active voluntary euthanasia, the municipal coroner would come to view the body and a police detective would come to interview the doctor. Both the municipal coroner and the police detective would then report to the public prosecutor. If it appeared that everything had been done in accordance with the guidelines, the prosecution would give permission to hand over the body to the relatives for burial. In circumstances where the doctor had acted properly and fully recorded in writing all the details of the case, this whole procedure would usually not take more than a couple of hours from the time of the reported death and the release of the body to the family. If, however, there was some reason to believe that all the criteria had not been complied with, a further investigation would be ordered by the public prosecutor, and the doctor would have to wait for some months before he or she would know whether a prosecution would result.¹⁹² Whilst this procedure was widely used, there was still no uniformity amongst the country's prosecutors, with the practice in some Dutch Provinces at variance with others. Of particular concern to the medical profession were instances of intrusive police investigation of active voluntary euthanasia cases and the inappropriate questioning of relatives of the deceased.

The courts have, on a number of occasions, confirmed the importance of accurate reporting of non-natural deaths by active voluntary euthanasia and have punished doctors for the falsification of death certificates.¹⁹³ Following the Royal Dutch Medical Association's direction to members to comply with the legal reporting requirements,¹⁹⁴ many more cases of active voluntary euthanasia were reported.¹⁹⁵ Nevertheless, it was evident that many cases of active voluntary euthanasia still went undetected with doctors continuing to falsify death certificates in order to conceal active voluntary euthanasia as the cause of death.¹⁹⁶ As a result of this widespread underreporting, it has been impossible to accurately gauge the extent of the practice of active voluntary euthanasia in the Netherlands by reference to the official figures held by the police and prosecuting authorities. Estimates have varied from 2,000 to 10,000 cases per year out of a total population of 14 million and

¹⁹⁰ Borst-Eilers, 'The Status of Physician-Administered Active Euthanasia in the Netherlands,' 5.

¹⁹¹ Sluyters, 40.

¹⁹² Borst-Eilers, 'The Status of Physician-Administered Active Euthanasia in the Netherlands,' 5.

¹⁹³ See above, n. 87.

¹⁹⁴ See above, 369.

¹⁹⁵ See Kennedy, 39; Borst-Eilers, 'Facts About the Actual Euthanasia Practice in the Netherlands', 3. In 1987 there were 122 reported cases of active voluntary euthanasia; in 1988 there were 181; in 1989 there were 336; and in 1990 there were 454; J. Keown, 'On Regulating Death' (1992) 22 *Hastings Center R.* 39, 41. In 1991, 590 cases were reported and by mid March 1992, there had already been 372 cases reported; N.V.V.E., Summary Euthanasie, June 1992, 3.

¹⁹⁶ Sluyters, 41; Keown, 'On Regulating Death', 41.

an annual total of approximately 130,000 deaths.¹⁹⁷ Some estimates have even been higher (mostly made by opponents of active voluntary euthanasia) and it has been suggested that the figure may be as high as 20,000.¹⁹⁸

As noted above, the Rummelink Committee was established by the government in order to obtain more precise information on the occurrence of active voluntary euthanasia in the Netherlands.¹⁹⁹ In framing the committee's terms of reference, it was decided to take the opportunity to investigate more widely medical decisions concerning the end of life. The committee's brief was to report on 'the state of affairs regarding the practice of commission or omission by a doctor leading to a patient's death, whether or not at the latter's explicit or serious request.'²⁰⁰ The aims of the study were: to produce reliable estimates of the incidence of active voluntary euthanasia and other medical decisions concerning the end of life; to describe the characteristics of patients, doctors, and situations involved; to assess how far doctors are acquainted with the criteria for acceptable euthanasia; and to determine under which conditions doctors would be willing to report a death by euthanasia as such.²⁰¹ Under the terms of reference, the role of the committee was simply to provide empirical data and not to give an opinion on the moral or legal permissibility of active voluntary euthanasia.

After some negotiation, this study was conducted with the full support and co-operation of the Royal Dutch Medical Association.²⁰² One of the conditions laid down by the association for its support for members' participation in the survey was for the formal adoption by the prosecuting authorities of guidelines for the reporting and investigation of cases of active voluntary euthanasia. Following negotiations between the Royal Dutch Medical Association and the coalition government, agreement was reached that the revised procedures would be formally adopted and would form the basis for the reporting and investigation of all cases of active voluntary euthanasia. The new protocol was

¹⁹⁷ De Wachter, 3316; Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 161 referring to estimates that there are 5,000-8,000 cases each year.

¹⁹⁸ For example, R. Fenigsen, 'A Case Against Dutch Euthanasia' (1989) 19 *Hastings Center R.* 22 where he notes that figures as high as 18,000 or 20,000 have been mentioned. See also P. Schepens, 'Euthanasia, Our Own Future?' (1987) 97 *News Exchange of the World Federation of Doctor Who Respect Human Life* 5, 6, citing K. Gunning, 'Euthanasia in the Netherlands' (1987) 96 *News Exchange of the World Federation of Doctor Who Respect Human Life* 8 and C. Dessaur and C. Rutenfrans, *Mag de Dokter Doden? (Is the Physician Allowed to Kill?)* Querido Edition, Amsterdam (1986). For a general discussion regarding the prevalence of active voluntary euthanasia in the Netherlands see Gomez, 48-56.

¹⁹⁹ See above, 378.

²⁰⁰ Note, 'Euthanasia in the Netherlands' (1990) 300 *B.M.J.* 1093. For a report of the first results of this nation-wide survey, see van der Maas, *et al.* For the full Report (in Dutch) see P. van der Maas, J. van Delden and L. Pijnenborg, *Medische Beslissingen Rond het Levenseinde. Het Onderzoek Voor de Commissie Onderzoek Medische Praktijk Inzake Euthanasie* (1991). At the time of the completion of this thesis, an English translation of this report had just become available; P. van der Maas, J. van Delden and L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life: An Investigation Performed Upon Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia* Health Policy Monographs, Volume 2 (1992).

²⁰¹ Van der Maas *et al.*, 669. This article, which reports on the first results of this nation-wide survey, only addresses the first and second of these goals.

²⁰² See van Berkestijn, 'The Royal Dutch Medical Association and the Practice of Euthanasia and Assisted Suicide,' 4 where he notes that initially the central committee of the Royal Dutch Medical Association refused to participate in the inquiry because it feared that it would be used to push a political decision. However, since the association has always promoted openness in the practice of active voluntary euthanasia, the central committee agreed to an inquiry under stringent conditions pertaining mainly to the confidentiality of the data and the dependability of the inquiry.

introduced in November 1990 under the direction of the Minister of Justice. Under the new protocol, doctors are required to notify the coroner of all cases of active voluntary euthanasia.²⁰³ This aspect of the new protocol represents a significant change from the former procedures whereby the doctor would advise the police or the public prosecutor. This new procedure is apparently much preferred by the Dutch medical profession since it involves reporting to a medical colleague rather than to the legal authorities.²⁰⁴ Once notified, the coroner then investigates the matter and is required to prepare a report to the public prosecutor which is to include the coroner's assessment of whether the guidelines for the performance of active voluntary euthanasia have been adhered to. The matter is then referred to the public prosecutor. By virtue of the direction from the Minister of Justice, prosecutors are no longer to ask the police to investigate euthanasia cases unless there is some reason to suspect that there has not been compliance with the criteria. The new protocol also contains agreement that in circumstances where police investigation is necessary, the police are to exercise discretion in conducting their investigations.²⁰⁵ If, on the basis of the doctor's report and the advice from the coroner, (and where appropriate, consultation with the Inspector of Health) the prosecutor is satisfied that all requirements have been met, permission is given for the patient's body to be released to the family for burial. The doctor is then advised by the prosecutor that the case will be referred to the committee of Chief Prosecutors for final determination. Almost invariably, the decision taken by the prosecutor is endorsed by the committee of Chief Prosecutors and no charges are laid against the doctor.²⁰⁶

Report Findings

The Rummelink inquiry is, to date, the most comprehensive study to have been conducted with regard to the extent of the practice of active voluntary euthanasia in the Netherlands.²⁰⁷ Under the auspices of the Rummelink Committee, the study was conducted by a team of researchers from the Department of Public Health and Social Medicine, at Erasmus University, Rotterdam, headed by Professor van der Maas, with the co-operation of the Dutch Central Statistical Office. Three separate studies were undertaken as part of this survey: (i) detailed interviews with a sample of 405 doctors (comprised of general practitioners, nursing home doctors and clinical specialists); (ii) mailing of questionnaires to the doctors of a sample of 7,000 deceased persons; and (iii) a prospective study in which doctors interviewed in study (i) (referred to above) gave information concerning deaths in their practice in the six month period following the interview.²⁰⁸ An important feature of this survey was the

²⁰³ The information required is gathered by the completion of a standard form check-list.

²⁰⁴ Most coroners in the Netherlands are medically trained with a background in forensic medicine.

²⁰⁵ For example, by using non-marked police cars, avoiding police uniforms, and refraining from interviewing the relatives of the deceased unless absolutely necessary.

²⁰⁶ For example, in 1990, 454 cases were reported and officially investigated but no prosecutions were commenced. In 1991, 590 cases were reported and only one case was prosecuted. (Verbal communication with Chief Prosecutor Jitta, November 1991.) For brief discussion of this prosecution, see above, 366.

²⁰⁷ Note also the survey of Dutch general practitioners conducted by van de Wal *et al*, below, 386-387.

²⁰⁸ Van der Maas, *et al*, 669.

confidentiality of the inquiry, so that participating doctors could be expected to provide full information without fear of repercussions.²⁰⁹ In addition, the Minister of Justice guaranteed legal immunity in respect of all information collected in the three studies.²¹⁰

Significantly, the three studies yielded similar estimates of incidence.²¹¹ According to these studies, there were 2,300 cases of active voluntary euthanasia in the Netherlands in 1990 amounting to 1.8% of all deaths.²¹² Assisted suicide (i.e. where a doctor intentionally prescribes or supplies lethal drugs but the patient administers them) occurred in almost 400 cases (0.3% of all deaths).²¹³ At interview, doctors were asked if they had ever practised active voluntary euthanasia or assisted a suicide at the request of a patient. Fifty-four per cent confirmed that they had, and 24% had done so at least once during the previous 24 months. Doctors working in general practice performed active voluntary euthanasia most frequently (62% had performed active voluntary euthanasia, and 28% had done so during the previous 24 months.) Forty-four per cent of clinical specialists had previously performed active voluntary euthanasia, and 20% had done so in the previous 24 months. There was a relative low incidence of active voluntary euthanasia amongst nursing home doctors (only 12% had previously performed active voluntary euthanasia, and 6% had done so in the previous 24 months.)²¹⁴

A significant proportion of the doctors interviewed (34%) said that they had never practised active voluntary euthanasia or assisted suicide but could conceive of situations in which they would be prepared to do so.²¹⁵ The remaining 12% said that they could not conceive of any such situations but more than half of those (8%) indicated that they would be prepared to refer patients requesting active euthanasia or assistance in suicide to another doctor with a more permissive attitude.²¹⁶ From this data, the researchers conclude, that a large majority of doctors in the Netherlands see active voluntary euthanasia as an accepted element of medical practice under certain circumstances.²¹⁷

The study also found that in the Netherlands, over 25,000 patients per year seek an assurance from their doctors that they will be given assistance in form of active voluntary euthanasia if their suffering becomes unbearable.²¹⁸ Each year, there are approximately 9,000 explicit requests for active euthanasia or assisted suicide of which less than one third are agreed to.²¹⁹ The fact that many

²⁰⁹ This was a precondition for the co-operation of the Royal Dutch Medical Association. Above, n. 380.

²¹⁰ Van der Maas, *et al.*, 670. Included in the data are figures regarding the withholding or withdrawing of treatment but analysis of these results is beyond the scope of this thesis.

²¹¹ *Id.* 671.

²¹² Van der Maas, *et al.*, 673.

²¹³ *Id.* 671.

²¹⁴ *Ibid.*

²¹⁵ *Ibid.*

²¹⁶ *Ibid.*

²¹⁷ *Ibid.*

²¹⁸ *Ibid.*

²¹⁹ *Ibid.*

requests are not acted upon can, at least in part, be explained on the basis that in many cases doctors can offer alternatives which render active voluntary euthanasia unnecessary.²²⁰

Significantly, many of the doctors who had practised active voluntary euthanasia indicated that they would be reluctant to do so again, other than in exceptional circumstances; i.e. in cases of unbearable suffering where there are no alternatives.²²¹ Many of the respondents indicated that an emotional bond between doctor and patient is required for the administration of active voluntary euthanasia. The researchers conclude that this may be one reason why active voluntary euthanasia was more common in general practice where doctor and patient have often known each other for years and the doctor has shared part of the patient's suffering.²²²

Compliance with the Guidelines

Whilst the study found that there was a high degree of knowledge of the guidelines for the practice of active voluntary euthanasia on the part of doctors,²²³ doctors' compliance with these guidelines was variable. Requests for active voluntary euthanasia and assisted suicide, in cases where this request was fulfilled, were explicit and persistent requests and, in the view of the attending doctor, were hardly ever made under pressure from others.²²⁴ On the basis of data obtained from interviews with doctors, in 96% of instances of active voluntary euthanasia and assisted suicide, the doctor stated that the patient's request was explicit and persistent. In 94% of cases, the request had been made repeatedly and in 99% of cases, the doctor felt sure that the request had not been made under pressure from others. In all cases, the doctors were convinced that the patient had sufficient insight and knowledge of the course of disease to make an informed decision.²²⁵ In most cases, (84%) there had been consultation with a colleague before the decision to perform active voluntary euthanasia had been acted upon, and in nearly all cases the decision had been discussed with relatives.²²⁶ In the great majority of cases, (79%) there was no alternative treatment available, or if available, the patient had refused that treatment (17%).²²⁷ Doctors were less compliant with the requirement of documenting cases of active voluntary euthanasia by the preparation of a written report (60%).²²⁸ Even fewer (28%) were prepared to notify the authorities of their actions.²²⁹ However, even during the course of the prospective study

²²⁰ *Id.* 672, 673. Other possible explanations include a change of mind by the patient, cases where the patient died before the request could be implemented, and cases where the doctor is not satisfied that the criteria for active voluntary euthanasia (e.g. voluntariness or unbearable suffering) are made out.

²²¹ *Ibid.*

²²² *Ibid.*

²²³ P. van der Maas, J. van Delden and L. Pijnenborg, 'Euthanasie en Andere Medische Beslissingen Rond Het Leenseinde in Nederland. II. Zorgvuldigheid en Melding' (1991) 135 *Ned Tijdschr Geneeskde* 2082, 2083.

²²⁴ *Id.* 672.

²²⁵ *Ibid.*

²²⁶ Verbal communication with the principal researcher, Professor van der Maas, December 1991.

²²⁷ *Ibid.*

²²⁸ *Ibid.*

²²⁹ Verbal communication with Professor van der Maas, December 1991, referring to the full report (in Dutch) at 38. In 1990 only 454 of the estimated 2,300 deaths by active euthanasia were reported.

in which doctors were required to give information concerning every death in their practice over a six month period, there was a notable increase in the incidence of reporting.²³⁰

Pursuant to the Rummelink Committee's terms of reference, the study also sought to ascertain the incidence of cases where a doctors assists in the termination of life other than at the explicit and persistent request of the patient. The study found that in 0.8% of cases (accounting for approximately 1,000 deaths per year), drugs were administered with the explicit intention to shorten the patient's life without an explicit and persistent request from the patient.²³¹ However, in more than half of these cases, this possibility had already been discussed with the patient, or the patient had expressed in a previous phase of the disease a wish for active voluntary euthanasia if his or her suffering became unbearable.²³² In other cases, possibly with a few exceptions, the patients were near to death and clearly suffering grievously, yet verbal contact had become impossible. The decision to hasten death was then nearly always taken after consultation with the family, nurses or one or more colleagues. In most cases, according to the doctors, the amount of time by which life had been shortened was a few hours or days only.²³³ In the report of the Rummelink Committee accompanying the research findings these cases were described as 'providing assistance to the dying'.²³⁴ According to the committee, the justification of such acts was that the suffering of the patient had become unbearable, and that according to strict medical norms, the life of the patient must be considered over, with death soon likely to occur, regardless of medical intervention.²³⁵

The study also examined cases where dosages of pain-relieving drugs were administered with the potential effect of shortening the patient's life. This category accounted for 17.5% of all deaths. The study found that in 6% of cases where pain medication was administered with possible lethal effect, (2% of total deaths) the drugs were administered with the express purpose of accelerating the death of the patient.²³⁶ In about 40% of such cases, the decision to increase dosages and the possibility that this might hasten the end of life, had been discussed with the patient.²³⁷ In cases where it had not, such discussion had usually been impossible because the patient was incompetent (73% of cases).²³⁸ Whilst there are clearly some similarities between this category and cases of active euthanasia, the doctors involved felt there was a material difference. Certainly in terms of methods used²³⁹ and the

²³⁰ An increase in the range of 30-35% was recorded in the study by van der Maas *et al.*

²³¹ Van der Maas, *et al.*, 671, 672.

²³² *Ibid.* In a small proportion of cases, (approximately 1%) patients had previously made a written declaration indicating their desire for active voluntary euthanasia in the event that their suffering became unbearable. Verbal communication with Professor van der Maas, December 1991, referring to the full report (in Dutch) at 34-35.

²³³ Van der Maas, *et al.*, 672.

²³⁴ H. ten Have and J. Welie, 'Euthanasia: Normal Medical Practice?' (1992) 22 March/April *Hastings Center R.* 34, 35.

²³⁵ *Ibid.*

²³⁶ Van der Maas, *et al.*, 672. In 15.5% of the total deaths, pain-relieving drugs were administered partly with the purpose of accelerating the end of life.

²³⁷ Van der Maas, *et al.*, 672.

²³⁸ *Ibid.*

²³⁹ The administration of active voluntary euthanasia usually involves curare or insulin whereas morphine and opiates are administered for pain relief.

certainty and proximity of death following the administration of those drugs, the two categories can be differentiated.²⁴⁰

In the report accompanying the research findings, the Rummelink Committee recommended that in relation to the consultation requirement, in order to get an independent medical judgment, the general practitioner who is considering the administration of active voluntary euthanasia should consult a specialist (preferably one who is already in attendance) and vice versa. This was thought to be an important element in ensuring the quality of the decision-making process. The committee also expressed the view that all doctors must strictly observe the requirements for scrupulous care in cases of active voluntary euthanasia, with particular emphasis being placed on the requirement of a written report. It was felt that this would enhance the decision-making process and would enable doctors to demonstrate their willingness to justify their conduct. It was also recommended that the new protocol for reporting cases of active voluntary euthanasia, introduced in November 1990, should also apply to cases of active termination of life by a doctor without an explicit request from the patient.²⁴¹

Evaluation of the Rummelink Committee's Findings

The study conducted by van der Maas *et al*, under the auspices of the Rummelink Committee, is widely regarded as being a reliable and credible investigation. It was the first nation-wide study to be undertaken on the subject and involved a large number of respondents. Due to the support of the Royal Dutch Medical Association, there was a high participation rate amongst members of the medical profession.²⁴² Moreover, because of the anonymity and legal immunity assured to doctors participating in the study, there is good reason to believe that the respondent doctors were answering truthfully. As a result, there is widespread acceptance of the research findings as accurately reflecting medical practice in the Netherlands. Whilst the release of the Rummelink Report has eliminated much of the speculation with regard to the extent of the practice of active voluntary euthanasia in the Netherlands, some Dutch commentators believe that it has also raised many new questions.²⁴³ Although the findings of the research group are not in dispute, differences exist in the interpretation of the results.²⁴⁴ The report has generally been received in the Netherlands as demonstrating that active voluntary euthanasia is a well controlled and workable medical practice and that the incidence of this

²⁴⁰ Verbal communication with Professor van der Maas and Dr van Delden, November/December 1991.

²⁴¹ See the full report (in Dutch) 37-38. The committee was, however, of the view that this was not necessary in cases where there is already an irreversible failure of vital functions.

²⁴² Verbal communication with Dr Dillmann, staff member - ethical affairs, Royal Dutch Medical Association, November 1991.

²⁴³ Verbal communication with Dr de Wachter, November 1991.

²⁴⁴ There has been particular conflict with regard to the 1,000 cases of termination without an explicit and persistent request and the cases where pain-relieving drugs were administered with the express purpose of hastening death. Whilst many commentators and persons interviewed by the writer in the Netherlands have expressed satisfaction with the research findings in the belief that active voluntary euthanasia is an exceptional and controlled practice others have suggested that the findings present cause for alarm; e.g. R. Fenigsen, 'The Report of the Dutch Governmental Committee on Euthanasia' (1991) 7 *Issues Law & Med.* 339; J. Fleming, 'Euthanasia, the Netherlands, and Slippery Slopes' Bioethics Research Notes, Occasional Paper No. 1 June 1992.

practice is not as extensive as had frequently been alleged. Opponents of active voluntary euthanasia, on the other hand, have cited the findings to demonstrate the alarming extent of the practice.²⁴⁵ Criticism has also been levelled at some aspects of the Rummelink Committee's interpretation of the research findings, particularly with regard to the category of patients whose lives were terminated in the absence of an explicit and persistent request from the patient.²⁴⁶ Some commentators are of the view that the committee has deliberately glossed over these findings in an attempt to make the results of the study politically acceptable.²⁴⁷

The results of the study by van der Maas *et al* tend to confirm the results obtained from a number of smaller surveys, and in particular, a survey of general practitioners and nursing home doctors undertaken by van de Wal *et al*, Public Health Inspector of the Province of North Holland, under the auspices of the Department of Family Medicine and Nursing Home Medicine at the Free University of Amsterdam.²⁴⁸ The study by van de Wal *et al* was confined to family doctors in the Netherlands and was conducted by means of an anonymous questionnaire sent to 1,042 family doctors. The study found that Dutch family doctors practice active voluntary euthanasia/assisted suicide about 2,000 times per annum. It was estimated that Dutch family doctors receive an average of 5,000 requests for active voluntary euthanasia/assisted suicide, and that an average of 40% of all requests lead to actual administration. Further, the study found that 48% of family doctors in the Netherlands have never engaged in these practices.

The study also sought to gauge the extent to which family doctors in the Netherlands comply with the guidelines for the practice of active voluntary euthanasia. The study found that most family doctors satisfy the requirements for prudent practice with regard to voluntariness of the patient's request;²⁴⁹ that it is a well considered and durable request;²⁵⁰ and the unbearable and pointless nature of the patient's suffering. Moreover, in the majority of cases, there were no further treatment options available. In those cases where treatment options remained, they offered no prospect of cure, and in most cases the patient had refused this further treatment. The study found that there was less compliance with the requirements of consultation, documentation and reporting of cases of active voluntary euthanasia: 25% of family doctors had not consulted another doctor prior to performing active voluntary euthanasia or assisted suicide; almost half (48%) of all family doctors had kept no written record of their last case of active voluntary euthanasia or assisted suicide; and 74% had falsely

²⁴⁵ For example, K. Gunning, 'Euthanasia' (letter) (1991) 338 *Lancet* 1010; A. Fergusson *et al*, 'Euthanasia' (letter) (1991) 338 *Lancet* 1010.

²⁴⁶ For example, ten Have and Welie, 35.

²⁴⁷ *Ibid.*

²⁴⁸ G. van der Wal *et al*, 'Euthanasia and Assisted Suicide: I. How Often Practiced by Family Doctors in the Netherlands?' (1992) 9 *Fam. Practice* 130, and 'Euthanasia and Assisted Suicide: II. Do Dutch Family Doctors Act Prudently?' (1992) 9 *Fam. Practice* 135.

²⁴⁹ This was ascertained by questions as to who had taken the initiative in arranging a discussion with the family doctor about active voluntary euthanasia and the reasons for the patient's request.

²⁵⁰ Whether the request was well considered was ascertained by questions regarding the reasons given for the patient's request and the existence or non-existence of other forms of treatment. The durability of the request was gauged by reference to the time lapse between the first discussion, the first and last explicit request and the actual implementation.

issued a certificate testifying to death from natural causes. A positive correlation was found to exist between obtaining a second opinion, preparing a written report and not falsifying the death certificate.

On the basis of the Rummelink inquiry and the earlier study by van der Wal *et al*, which have yielded similar results thereby confirming the accuracy of these surveys, certain conclusions can be drawn with regard to the practice of active voluntary euthanasia in the Netherlands. The results refute the assertion that active voluntary euthanasia occurs on an excessive scale in the Netherlands and that it is used increasingly as an alternative to good palliative or terminal care. The extent of the practice appears to be in the range of 2,300 a year, and is most frequently performed by general practitioners. The studies also indicate that doctors are generally reluctant to engage in the practice and that a significant proportion of requests for active voluntary euthanasia are refused. The research findings do, however, confirm that not all doctors are complying with the stipulated guidelines with regard to the practice of active voluntary euthanasia, particularly with regard to the need for consultation, documentation and reporting of the practice.

The study by van der Wal *et al* also examined the incidence of active euthanasia other than at the request of the patient. According to the findings of this study, there are approximately 100 cases per year of active euthanasia performed by family doctors in Holland without the explicit and persistent request of the patient, and these cases almost invariably involved exceptional circumstances.²⁵¹ Although this survey was confined to family doctors in Holland, the results obtained by van der Wal *et al* with regard to active terminations without request appear to be significantly lower than this aspect of the findings of the Rummelink inquiry.²⁵²

Expanding Boundaries?

The unique developments in the Netherlands have naturally been the focus of interest in Australia and other jurisdictions where there is increasing pressure for the legalisation of active voluntary euthanasia. As we have seen, one of the major obstacles for change is concern regarding the operation in practice of a law which permits active voluntary euthanasia and fear of the 'slippery slope'.²⁵³ There have been claims by a few vocal dissenters that there is already evidence in the Netherlands of the adverse consequences of any loosening of the legal prohibition on the practice of active voluntary euthanasia.²⁵⁴ Assertions have been made about the growing incidence of active euthanasia in the Netherlands and that the practice has extended to non-voluntary and even involuntary euthanasia, overstepping ethical bounds and administrative controls.²⁵⁵ From this premise, it is inevitably

²⁵¹ G. van der Wal *et al*, 'Actieve Levensbeëindiging Door Huisartsen Zonder Verzoek van der Patiënt' (1991) 34 *Huisarts en Wetenschap* 523.

²⁵² See above, 384 where it was estimated that there were approximately 1,000 cases of active terminations of life other than at the explicit and persistent request of the patient.

²⁵³ See chapter V, 202-205.

²⁵⁴ See, for example, Fenigsen, 'A Case Against Dutch Euthanasia,' 22; Bostrom, 467; J. Segers, 'Elderly Persons on the Subject of Euthanasia' (1988) 3 *Issues Law & Med.* 407; Desssaur and Rutenfrans, 399; van der Sluis, 455; A. Capron, 'Euthanasia in the Netherlands: American Observations' (1992) 22 *Hastings Center R.* 30; D Callahan, 'When Self-Determination Runs Amok' (1992) 22 *Hastings Center R.* 52, 54; Gomez, 127-139.

²⁵⁵ For example, B. Pollard, 'Medical Aspects of Euthanasia' (1991) 154 *M.J.A.* 613.

argued by opponents of active voluntary euthanasia that the Netherlands would be a very dangerous model for other countries to follow.²⁵⁶ In support of these claims, Dutch cases are cited where patients were killed without their consent by nurses and/or doctors, but negligible punishment was imposed on the offender.²⁵⁷ It is also alleged that there is growing support for non-voluntary euthanasia amongst prominent advocates of voluntary euthanasia,²⁵⁸ and the Dutch community generally.²⁵⁹

As a result of the 'uncontrollable nature' of euthanasia, especially when it is performed by doctors who work alone (for example, family doctors or nursing home doctors), it is claimed that many people, particularly elderly nursing home residents, are fearful that they will be subject to non-voluntary euthanasia.²⁶⁰ It has further been alleged that the acceptance of active voluntary euthanasia has resulted in a change of attitude of doctors towards patients who are disabled by illness or accident but who do not meet the guidelines for active voluntary euthanasia.²⁶¹ This change, it is claimed, is reflected in decisions regarding withdrawal of treatment from these patients without their knowledge or consent as well as pressure being placed on patients by doctors to 'voluntarily' request active euthanasia.²⁶² Claims have also been made that the availability of active voluntary euthanasia has hindered the development of hospice and palliative care in the Netherlands, with the result that inferior care is available to the terminally ill. In turn, it is argued that patients who are not given appropriate pain relief and other care are more likely to be driven to request active voluntary euthanasia.²⁶³

These assertions have, however, been sharply rejected, particularly by members of the Dutch medical profession, as being completely unfounded and portraying a misleading picture of the practice of active euthanasia in the Netherlands.²⁶⁴ A number of distinguished Dutch commentators have pointed out that the foreign press (including specialist journals) has tended to seize upon the allegations being made by a hard core minority opposed to the practice of active voluntary euthanasia and give them

²⁵⁶ *Id.* 616.

²⁵⁷ For example, the much publicised killings in the De Terp nursing home where a number of patients had allegedly been killed without their knowledge or consent by the head nurse on the doctor's orders. The doctor subsequently pleaded guilty and was convicted of three killings. He was sentenced to one year imprisonment. On appeal, the Court of Appeal of the Hague reversed the sentence on the grounds that the criminal investigators had transgressed their competence by seizing documents which were legally privileged. Because the evidence had been wrongfully obtained it was inadmissible in court. The doctor was however disciplined by the Medical Disciplinary Court of the Hague; Bostrom, 476; van der Sluis, 463; Fenigsen, 'A Case Against Dutch Euthanasia,' 23; Pollard, 613; Keown, 'The Law and Practice of Euthanasia in the Netherlands,' 69.

²⁵⁸ Keown, 'The Law and Practice of Euthanasia in the Netherlands,' 75-76.

²⁵⁹ Pollard, 615.

²⁶⁰ Bostrom, 477; Segers, 407; Fenigsen, 'A Case Against Dutch Euthanasia,' 26.

²⁶¹ Bostrom, 479-480.

²⁶² *Ibid.*

²⁶³ Verbal communication with Dr. Willebois, former president of the Nederlands Artsenverbond (Dutch League of Physicians), November 1991.

²⁶⁴ See, for example, the reaction to the publication of the article by Fenigsen in the *Hastings Centre Report*, 'A Case Against Dutch Euthanasia'. This led to the adoption of a motion by the General Assembly of the Dutch Society of Health Law and its publication in the *Hastings Center Report* claiming that Fenigsen's account was incorrect and misleading, as well as a letter of complaint signed by numerous prominent Dutch doctors. See also H. Rigter, 'Euthanasia in the Netherlands: Distinguishing Facts from Fiction' (1989) 19 *Hastings Centre R.* 31; Leenen 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 525.

disproportionate attention.²⁶⁵ This has resulted in a very inaccurate and unreliable impression being conveyed outside of the Netherlands about the extent and nature of the practice of active euthanasia in that country.²⁶⁶ For some time, the absence of reliable data (at least until the recent Rummelink survey) tended to fuel speculative claims and there was no firm basis upon which these claims could be refuted.

However, the data obtained by the Rummelink Committee survey has dispelled claims about the growing and uncontrollable nature of the practice of active voluntary euthanasia in the Netherlands.²⁶⁷ Results from that survey, and from a number of other inquiries,²⁶⁸ have shown that the occurrence of active voluntary euthanasia is in fact much less than had earlier been thought. Indeed, some commentators in the Netherlands contend that there is no indication that active euthanasia on request is practised more often in the Netherlands than in other countries.²⁶⁹ Rather, they suggest that in the Netherlands, a practice which was formerly kept behind closed doors, as is the case in many other countries, has now been brought into the open.²⁷⁰ Contrary to claims that once doctors become 'killers,' there is the danger that killing comes all too easily, data from the Rummelink survey found that doctors who have performed active voluntary euthanasia indicated that they would be most reluctant to do so again and would only do so in the face of unbearable suffering where there were no other alternatives.²⁷¹ This is supported by other anecdotal evidence which suggests that few Dutch doctors seem eager to hasten the deaths of their patients.²⁷²

Critics of the Dutch position contend that the guidelines which supposedly regulate the practice of active voluntary euthanasia in the Netherlands are hopelessly vague and imprecise.²⁷³ It is argued that the failure of doctors to comply with the guidelines, and in particular, the requirement to report cases of active voluntary euthanasia, means that the practice remains unverifiable and uncontrollable.²⁷⁴ In support of such assertions, critics draw upon the findings of the Rummelink study that in a significant proportion of cases (approximately 1,000 or 0.8% of all deaths), doctors performed acts of termination without an explicit and persistent request from the patient. This, they argue, demonstrates the occurrence of non-voluntary euthanasia.

²⁶⁵ For example, van Berkestijn, 'The Royal Dutch Medical Association and the Practice of Euthanasia and Assisted Suicide,' 8-9; Leenen, 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients,' 1.

²⁶⁶ Van Berkestijn, 'The Royal Dutch Medical Association and the Practice of Euthanasia and Assisted Suicide,' 9.

²⁶⁷ Professor van der Maas, the principal researcher, has said, in response to questions regarding the interpretation of the study, that the data should be interpreted as indicating that on the whole in the Netherlands, there is a reliable practice of taking decisions concerning the end of life; see Note, 'Medical Aid in Dying in the Netherlands' (1992) Vol. 9 No. 3 *S.A.V.E.S. Bull.* 4.

²⁶⁸ See discussion above, 386-387 of the study by van der Wal *et al.*

²⁶⁹ For example, Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 525.

²⁷⁰ *Ibid.*

²⁷¹ Van der Maas *et al.*, 673.

²⁷² Pence, 141 and information obtained in interviews conducted by the writer with a number of doctors in the Netherlands, November/December 1991.

²⁷³ Keown, 'The Law and Practice of Euthanasia in the Netherlands,' 61-66; Gomez, 95-125.

²⁷⁴ Keown, 'The Law and Practice of Euthanasia in the Netherlands,' 67; Gomez, 117-139.

To begin with, there is some basis for suggesting that the incidence of active termination of life without the patient's request reported in the Rummelink survey may be disproportionately high. According to the study by van der Wal *et al*, of more than 1,000 family doctors in Holland, it was found that such cases occur approximately 100 times a year in general practice in the Netherlands. If one extrapolates from this figure to the medical profession as a whole, it would still be significantly less than the findings of the Rummelink survey. In view of the close correlation between the two surveys' with respect to most other matters, this discrepancy does perhaps raise some doubt as to the correctness of the findings of the Rummelink survey. However, even if one accepts the results of the Rummelink survey as accurately reflecting the incidence of active terminations without the patient's explicit and persistent request, there are a number of grounds on which the critics' claims can be countered. One point which can be made is that whilst these cases clearly did not strictly comply with the guidelines for the performance of active voluntary euthanasia, closer analysis of this category reveals that 'non-voluntary euthanasia' is not an appropriate label for the majority of these cases; in more than half of these cases the decision was discussed with the patient or the patient had previously expressed a wish for active euthanasia in the event that his or her suffering became unbearable.²⁷⁵ In most of the remaining cases where there was no consultation with the patient, the patients were near to death, suffering grievously and no longer competent. Moreover, there is no evidence to suggest that the incidence of these cases where life is terminated in the absence of an explicit and persistent request is the product of the *de facto* acceptance of active voluntary euthanasia in the Netherlands. In contrast to cases of active euthanasia, where in the great majority of cases, life is shortened by at least one week and in many cases by a period of some months,²⁷⁶ in most of these cases, life had been shortened by a few hours or days at the most and the patient had been in a state of extreme suffering.²⁷⁷ It is therefore arguable that these cases, which undoubtedly also occur in other jurisdictions, are unconnected with developments in the Netherlands with regard to active voluntary euthanasia.

There is also another major ground for the rejection of the critic's reasoning that the figures regarding active terminations without the patients' explicit and persistent request is evidence of a 'slippery slope'. In order to substantiate a 'slippery slope' argument, it would need to be shown that cases of non-voluntary euthanasia occur more frequently now than they did prior to the quasi-legalisation of active voluntary euthanasia in the Netherlands. There is, however, no evidence to suggest that the

²⁷⁵ See also B. Sneide(r)man, 'Euthanasia in the Netherlands: A Model for Canada?' (1992) 8 *Humane Med.* 104, 111.

²⁷⁶ Van der Maas *et al*, 672.

²⁷⁷ *Ibid.* This has been confirmed in discussions with the principal researcher, Professor van der Maas, December 1991.

incidence of such cases is increasing.²⁷⁸ The Rummelink report is the first extensive study of its kind so no such figures are available.²⁷⁹

Critics have also seized upon the results with regard to the administration of pain-relieving drugs where the drugs were administered with the express purpose of accelerating the death of the patient.²⁸⁰ This category of cases (accounting for 6% of cases where pain medication was administered with possible lethal effect, and 2% of total deaths) is difficult to interpret.²⁸¹ It is, admittedly, somewhat illogical to say that drugs are administered for pain relief with the explicit purpose of hastening death, unless, of course, it is accepted that it was necessary to end the patient's life in order to relieve the patient's pain. It has been suggested that this category of cases is a product of the continuing illegality of active voluntary euthanasia and the resulting tendency of some doctors to conceal their actions.²⁸² The intention in these cases is virtually indistinguishable from that of a doctor performing active voluntary euthanasia. Consultation had taken place with the patient in nearly half these cases yet the doctors were clearly not willing to openly perform active voluntary euthanasia.

One aspect of the 'slippery slope' argument which has been raised in opposition to active voluntary euthanasia generally²⁸³ and has surfaced in the debate over the practice of active voluntary euthanasia in the Netherlands²⁸⁴ is that acceptance of active voluntary euthanasia will lead to a loss of respect for human life. It has, however, been vigorously denied by doctors and commentators in the Netherlands that the open practice of active voluntary euthanasia in the Netherlands has led to a lesser respect for human life in that country.²⁸⁵ Indeed, many doctors have defended the Dutch position and argue that to perform active voluntary euthanasia, as limited by the guidelines, is in fact an act of respect for that patient as person.²⁸⁶

Contrary to the claims of their critics, many of those who are involved in the administration of active voluntary euthanasia in the Netherlands assert that there have been a number of beneficial outcomes of the liberalisation of the law and practice. In addition to providing relief to many patients from an existence of subjectively intolerable suffering, it has been suggested that the contemporary debate on the subject of active voluntary euthanasia has had positive consequences for patients generally in that

²⁷⁸ H. Kuhse, 'Voluntary Euthanasia in the Netherlands and Slippery Slopes' (1992) Vol. 11 No. 4 *Bioethics News* 1, 4-6. See also Sneiderman, 112, 113. By the same token, however, as Kuhse points out, the findings of the Rummelink inquiry cannot be used as evidence to categorically refute the slippery slope.

²⁷⁹ *Ibid.*

²⁸⁰ For example, Fenigsen, 'The Report of the Dutch Governmental Committee on Euthanasia,' 340-344.

²⁸¹ Verbal communication with Professor van der Maas, December 1991.

²⁸² For example, Dr Admiraal, verbal communication, November 1991.

²⁸³ See chapter V, 205-206.

²⁸⁴ Bostrom, 467.

²⁸⁵ Borst-Eilers, 'Facts About the Actual Euthanasia Practice in the Netherlands', 12.

²⁸⁶ P. Admiraal, 'Active Voluntary Euthanasia' (1985) *New Humanist* 23, 24. This view was also expressed by Dr Admiraal and other Dutch doctors in interviews with the writer, November/December 1991.

is has led to a re-evaluation of the patient's role as an actor in the decision-making process.²⁸⁷ Others see advantages from the practice of active voluntary euthanasia in the Netherlands in that the subjects of death, illness and ageing have lost much of their terror.²⁸⁸ This is, to some extent, borne out by the results of the Rummelink survey which found that a large number of patients seek assurance from their doctors that active voluntary euthanasia will be available if their suffering becomes unbearable.²⁸⁹ The very fact that these assurances are sought and given, even though active voluntary euthanasia is only performed in a small proportion of these cases, highlights the importance of the availability of active voluntary euthanasia for the patient's peace of mind. For many patients facing terminal illness, it is the prospect of uncontrollable suffering and loss of dignity which they fear most, and if they can be given an assurance by their doctor that assistance will be available in the event that it becomes necessary, it appears that much of this anxiety can be avoided.

Government's Response to the Rummelink Report

The release of the Rummelink survey has made it possible for the Dutch government to decide on the desirability of legislation from a reasonably informed basis. In April 1992, the government withdrew its draft law of 1987 and submitted a new Bill.²⁹⁰ The current legislative proposal seeks to implement the recommendations of the Rummelink Committee. It leaves Article 293 of the *Penal Code* 1886 unchanged²⁹¹ and merely gives effect to the protocol introduced in November 1990 regarding reporting procedures for doctors performing active voluntary euthanasia. This is to be achieved by an amendment to the Act dealing with the disposal of the dead so as to permit the promulgation of regulations by the Queen.²⁹² This represents a significant retreat from the earlier proposal of the Christian Democrats-Conservatives coalition under which the carefulness requirements to be followed by a doctor performing active voluntary euthanasia were actually to be specified in the legislation dealing with medical practice. Moreover, the form of the current proposal is also less expansive, involving secondary legislation (promulgation of regulations) which will be more readily open to amendment than if the change were embodied in an Act of parliament.

In accordance with the recommendations of the Rummelink Committee, the coalition government's current proposal also requires that cases of termination of life without the express and explicit request of the patient be reported in the same way as cases of active voluntary euthanasia. The expectation of the government is that such cases should be investigated and, where appropriate, prosecuted. It should be noted that such cases would come within the murder provisions of the *Penal Code* 1886 rather than

²⁸⁷ H. Bakker-Winnubst, 'The Right to Euthanasia During the Terminal Stage of Life' in Aycke and Smook, 39, 43. See also P. Admiraal, 'Is There a Place for Euthanasia?' (1991) Vol. 10 No. 4 *Bioethics News* 10, 11 where he notes the importance now attached to patient self-determination.

²⁸⁸ H. Cohen, 'Euthanasia As a Way of Life' in Aycke and Smook, 61.

²⁸⁹ See above, 382.

²⁹⁰ J. Gevers, 'Legislation on Euthanasia: Recent Developments in the Netherlands' (1992) 18 *J. Med. Ethics* 138, 140.

²⁹¹ The earlier proposal for the reduction of penalty is not included in this proposed amendment.

²⁹² Verbal communication with Professor Leenen, November 1991.

Article 293 (dealing with killing on request). Even in the absence of a request for active euthanasia, it is possible that the defence of necessity in Article 40 of the Code would apply.

The current legislative proposal, has however, come in for criticism on a number of grounds.²⁹³ Many regard the proposal as an inept political compromise. One of the principal criticisms is that it is illogical and contradictory to have under one Act a law which unequivocally prohibits active voluntary euthanasia (Article 293 of the *Penal Code* 1886), and at the same time, to contemplate amendments to other legislation which appear to condone the practice of active voluntary euthanasia.²⁹⁴ It has also been argued that the implementation of this proposal will, in any event, not achieve the desired object of securing full reporting by doctors of cases of active voluntary euthanasia since the practice remains a criminal offence under the *Penal Code* 1886, and there will always be a proportion of doctors who are not willing to report in these circumstances.²⁹⁵ One aspect of the proposal which has attracted particular criticism has been the decision to treat cases of termination of life without the express and explicit request of the patient in the same way as cases of active voluntary euthanasia.²⁹⁶ Many people are concerned that this blurs the crucial distinction between voluntary and non-voluntary euthanasia and tends to imply that termination of life other than at the express and explicit request of the patient may, in some circumstances, be acceptable.²⁹⁷ The views of a number of leading legal commentators in the Netherlands is that cases of this kind are exceptional and cannot be legislated for.²⁹⁸

Arguments for Legislative Reform in the Netherlands

Notwithstanding the significant jurisprudential developments and the general compliance of prosecuting authorities in bringing prosecution policy in line with the case law developments, a number of problems have been identified with the current position in the Netherlands.²⁹⁹ Foremost amongst these problems is the continuing legal uncertainty faced by doctors as a result of the inconsistency between law and practice with regard to active voluntary euthanasia.³⁰⁰ At present, active voluntary euthanasia is still prohibited under Article 293 of the *Penal Code* 1886, and doctors who engage in the practice are committing a criminal offence. Whilst the courts can, to some extent, bridge the gap between legislation and the practice of active voluntary euthanasia in the Netherlands,

²⁹³ For critical analysis of the government's proposal, see Gevers, 'Legislation on Euthanasia: Recent Developments in the Netherlands.'

²⁹⁴ I.e. the same argument that was raised against the earlier coalition proposal. A well-known and outspoken critic of both proposals is Professor Leenen. (Verbal communication, November 1991.)

²⁹⁵ Twenty-five per cent of doctors say that they will not report cases of active voluntary euthanasia whilst it remains illegal; Verbal communication with Dr Dillmann, staff member - ethical affairs, Royal Dutch Medical Association, November 1991.

²⁹⁶ Verbal communication with Professor Leenen, Dr Sutorius, and Dr Gevers, November/ December 1991.

²⁹⁷ *Ibid.* Professor Leenen suggests that this legislative proposal may even be in contravention of Article 2 of the *European Convention of Human Rights and Practices* 1953.

²⁹⁸ Verbal communication with Professor Leenen and Dr Gevers, November/ December 1991.

²⁹⁹ For detailed consideration of some of these problems, see Leenen, 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Competent Patients,' 5-6, 11-14.

³⁰⁰ *Ibid.*

there are inherent limitations in the capacity for case law to provide certainty in this area. Apart from certain minimum standards which have been more or less uniformly applied, there is no absolute certainty that all courts would abide by the same criteria which have been developed in the mainstream jurisprudence.³⁰¹ Thus, the possibility always exists that a doctor who has performed active voluntary euthanasia in accordance with established guidelines could face conviction and substantial punishment under Article 293.³⁰² The co-ordination of prosecution policy in conformity with the case law developments and more recently, the introduction of a uniform protocol for the reporting and investigation of cases of active voluntary euthanasia has, to a large extent, clarified the situation and removed some of the uncertainty. There is now some degree of confidence amongst the medical profession that doctors will not be prosecuted if they perform active voluntary euthanasia in accordance with the guidelines laid down by the courts and then report their actions as required under the new protocol. This is borne out by the significant increase in the number of reports of active voluntary euthanasia cases since the introduction of this protocol in November 1990.³⁰³ But, despite these developments, doctors who perform active voluntary euthanasia are still acting contrary to law and must carefully justify their actions in order to escape criminal liability. Their conduct can not be excused in advance, but only after reporting and investigation of the matter. Thus, some uncertainty inevitably remains and there is clear evidence that some doctors simply will not report cases of active voluntary euthanasia whilst the practice remains illegal.³⁰⁴ As a result, many cases of active voluntary euthanasia in the Netherlands are still performed behind closed doors and there is little possibility of fully controlling the practice. In the absence of adequate controlling mechanisms for the administration of active voluntary euthanasia, the interests of the patient are at risk. The recent survey results have shown that active euthanasia is performed quite frequently, and although in the majority of cases, it is performed at the explicit and persistent request of the patient, in a not insignificant proportion of cases, lethal drugs are administered without such a request.³⁰⁵ There is, therefore, some justification for calls for the introduction of legislation to establish effective control mechanisms and to protect against the possibility of patients' lives being terminated without their explicit request.³⁰⁶ Neither case law nor prosecution policy can provide the necessary clarity, legal uniformity and certainty, and it is only through legislation that the patient's right of self-determination can be specifically protected.³⁰⁷ On the basis of the foregoing arguments, there is a strong case for introducing legislation which, unlike the coalition proposal, actually legalises active voluntary

³⁰¹ Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands,' 202; Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands,' 523.

³⁰² Leenen, 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Competent Patients,' 5-6, 11-14.

³⁰³ An increase in excess of 30% is noted in the Rummelink report; Verbal communication with Dr Dillmann, staff member - ethical affairs, Royal Dutch Medical Association, November 1991.

³⁰⁴ See above, n. 295.

³⁰⁵ See above, 384 for discussion of the 0.8% of cases in which doctors terminated life without an explicit and persistent request, in approximately half of which there was no consultation with the patient. Note also the category of cases where pain-relieving drugs were administered with the express purpose of hastening the death of the patient. Although this possibility was discussed with the patient in 40% of cases, in many cases this was not possible because the patient was incompetent.

³⁰⁶ For example, Leenen, 'Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Competent Patients,' 11; Roscam Abbing, 73.

³⁰⁷ Roscam Abbing, 72-3. By virtue of the terms of Article 293 of the *Penal Code* 1886, case law has very much focussed on the position of the doctor, only indirectly referring to the autonomy of the patient.

euthanasia performed in accordance with strict safeguards (for example, along the lines of the Wessel-Tuinstra Bill).³⁰⁸ If active voluntary euthanasia were legalised, with the criteria for its performance clearly spelt out in the legislation, the onus would no longer be on doctors to prove their innocence. Instead, it would be for the prosecution to prove that the doctor had acted outside the criteria. Whilst it would be unrealistic to suppose that the introduction of legislation legalising the practice of active voluntary euthanasia would result in full reporting or completely eliminate the risk of inappropriate practices, it would certainly be an improvement on the present situation. There is good reason to believe that many more doctors would, in these circumstances, be willing to report cases of active voluntary euthanasia and subject themselves to legal scrutiny, and the practice would generally be more open.³⁰⁹

There certainly appears to be considerable support for the legalisation of active voluntary euthanasia amongst the Dutch medical profession and the community generally. According to figures obtained in the Rummelink survey, 60% of doctors are in favour of the introduction of a statutory immunity excluding doctors from the liability of Article 293 of the *Penal Code* 1886, provided the specified criteria are satisfied.³¹⁰ The Royal Dutch Medical Association is now also actively seeking legislation which allows an immunity to doctors. So far as community attitudes are concerned, opinion poll evidence suggests that a large majority of the Dutch population favours the introduction of legislation permitting active voluntary euthanasia.³¹¹

However, as some commentators have pointed out, there are also potential difficulties associated with the introduction of legislation which legalises active voluntary euthanasia. Gevers, for example, points out that there are inevitably limitations with legislation, in that it is impossible to delineate precisely the situations in which active voluntary euthanasia should be allowed.³¹² Consequently, a new law cannot add very much to what has already been developed by the courts and will only partially reduce legal uncertainty.³¹³ Some commentators have further argued that there is no evidence to suggest that there is less risk of abuse if the criteria are statutory.³¹⁴ Others who are opposed to legislation point out that in a democracy, law on any issue is a compromise solution and therefore likely to be unsatisfactory.³¹⁵ Related to this, is the possibility of difficulties being encountered in the interpretation of any new legislation. This concern has led some notable advocates

³⁰⁸ See above, 375.

³⁰⁹ Verbal communication with Dr Admiraal, November 1991. Support for this view can be found in the fact that 25% of doctors refuse to report cases of active voluntary euthanasia whilst the practice remains illegal; see above, n. 295.

³¹⁰ Verbal communication with Dr Dillmann, staff member - ethical affairs, Royal Dutch Medical Association, November 1991.

³¹¹ In a 1985 survey, 70% of respondents indicated their support for legislation; S. Waller, 'Trends in Public Acceptance of Euthanasia Worldwide' (1986) 1 *Euthanasia Rev.* 33, 41. For detailed analysis of public opinion in the Netherlands on the subject of active voluntary euthanasia, see H. Hilhorst, 'Religion and Euthanasia in the Netherlands: Exploring a Diffuse Relationship' (1983) 30 *Social Compass* 491.

³¹² Gevers, 'Legal Developments Concerning Active Euthanasia on Request in the Netherlands,' 162.

³¹³ *Ibid.*

³¹⁴ Keown, 77.

³¹⁵ Dr van Till, verbal communication, November 1991.

for active voluntary euthanasia, such as Dr Pieter Admiraal and Dr Herbert Cohen to express reservations about the introduction of legislation as the means for solving present difficulties.³¹⁶

Why the Netherlands?

A question which has often been raised is why the Netherlands appears to be at the forefront in the practice of active voluntary euthanasia. Many explanations have been advanced, some of which relate to the unique characteristics of the Netherlands and its people.

The Netherlands is a small, densely populated country. It has a pluriform society with a tradition of religious and moral tolerance.³¹⁷ It is a very democratic and permissive society which values freedom of thinking and expressing one's views. A variety of opinions exist in Dutch society from strict Calvinism and Catholicism to liberal Christianity and Humanism. In a population of 14 million, there are more than 380 churches or denominations.³¹⁸ Whilst Holland is nominally Catholic, Dutch Catholicism is very democratic and aggressively anti-Vatican.³¹⁹ A significant proportion of the Dutch population claim no religious affiliation. Dutch society as a whole is quite interested in moral issues such as active voluntary euthanasia, and the Dutch enjoy open and free discussion on such subjects.³²⁰ It is also a society where the views of others are respected. This community tolerance is reflected in the opinion poll results with regard to active voluntary euthanasia which show that a great majority (87%) of the Dutch population is quite tolerant of others who hold opposite attitudes on the subject.³²¹

Dutch people are also known for their fierce independence, moral integrity and defence of civil liberties.³²² The independence of Dutch doctors was demonstrated during the Nazi occupation when, despite threats and the withdrawal of their licences, they refused to play any part in the Nazi program of sterilisation of and medical experiments upon Jews, gipsies and mental defectives.³²³ As in other countries, there has been growing recognition in the Netherlands of the importance of individual autonomy and respect for the individuals right of self-determination, and this has directly contributed to the contemporary acceptance and practice of active voluntary euthanasia.³²⁴

³¹⁶ Kennedy, 39-45.

³¹⁷ This is, for example, illustrated in the liberal approach taken by the Dutch to prostitution and drug use. See also P. Zisser, 'Euthanasia and the Right to Die: Holland and the United States Face the Dilemma' (1988) *N.Y.L.Sch.J. Int'l. & Contemporary Law* 361, 363.

³¹⁸ H. Terborgh-Dupuis, 'The Netherlands: Tolerance and Teaching' (1984) 14 *Hastings Center R.* 23, 23.

³¹⁹ Pence, 139; Humphry and Wickett, 189-190.

³²⁰ Terborgh-Dupuis, 23.

³²¹ Hilhorst, 496.

³²² Pence, 139.

³²³ Kennedy, 32; L. Alexander, 'Medical Science Under Dictatorship' (1949) 241 *New Eng.J.Med.* 39.

³²⁴ See R. Dillmann, 'Euthanasia in a Dutch Perspective,' paper, Royal Dutch Medical Association (1991) 6-7; Borst-Eilers, 'The Status of Physician-Administered Active Euthanasia in the Netherlands', 7.

There are also special features of the Dutch health care system which have played a role in the development of active voluntary euthanasia. In the Netherlands, at the centre of the health care system is the family doctor, or 'huisarts', who has typically looked after the family for a number of years.³²⁵ Although doctors are esteemed, to many people they are like a family friend.³²⁶ In the context of provision of terminal care, much of the care is provided in the patient's home, with the family doctor making frequent house-calls to assure the patient of adequate pain control and symptom relief, and supported by nurses and other health care providers. Unlike many other Westernised countries where the majority of people die in hospitals, most patients in the Netherlands die at home, in their natural surroundings.³²⁷ The nature of the family doctor's relationship with his or her patients has important consequences with regard to the performance of active voluntary euthanasia. It is a relationship characterised by close personal contact in which the doctor has a good knowledge of the patient and his or her family circumstances, including any family support or pressures that might be relevant in a request for active euthanasia.³²⁸ A patient's family doctor would therefore be in a very good position to assess the voluntariness of the patient's request and other relevant factors in the euthanasia determination. Significantly, the Rummelink survey has confirmed that active voluntary euthanasia is most frequently practised by general practitioners.³²⁹

In addition to the key role played by the family doctor, it has also been suggested that the situation in the Netherlands has come about because of the openness of Dutch doctors; because some doctors were prepared to act openly in what they judged to be their patients' best interests and defend their actions in the law courts.³³⁰ The approach taken by these doctors contrasts markedly with the position in other countries such as Australia, the United Kingdom and the United States where the practice of active euthanasia is largely hidden. In those few cases where a doctor is exposed and faces prosecution, technical defences are usually invoked, and the case is generally not defended as a case of active voluntary euthanasia.³³¹

So far as jurisprudential developments are concerned, coincidence has arguably also played an important role.³³² When the first case came before the court in Leeuwarden in 1973, the Foundation of Voluntary Euthanasia heard of it and furnished the President of the court with a number of publications by lawyers, doctors, philosophers and theologians who did not condemn active voluntary euthanasia but found it acceptable if necessary as a last resort. Copies of these publications, which

³²⁵ H. Dupuis, 'The Right to a Gentle Death' in Aycke and Smook, 53, 56.

³²⁶ *Ibid.*

³²⁷ Dillmann, 8. This is to be compared, for example, with the United States where 80% of deaths occur in hospitals; see President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 17-18.

³²⁸ M. Battin, 'Seven Caveats Concerning the Discussion of Euthanasia in Holland' (1990) 34 *Perspectives in Biology & Med.* 73.

³²⁹ Sixty-two per cent of the general practitioners surveyed had performed active euthanasia compared with 44% of the clinicians and 12% of the nursing home physicians. Twenty-eight per cent of the general practitioners had performed active euthanasia within the previous 24 months compared with 20% of the clinicians and 6% of the nursing home physicians. For further discussion see above, 382.

³³⁰ South Australian Voluntary Euthanasia Society Fact Sheet No. 4, May 1990.

³³¹ See chapter IV, 123-127.

³³² Verbal communication with Dr. van Till, January 1991.

had appeared in medical journals (and therefore were probably unknown to the legal profession) went to the prosecutor and defence in this case. This meant that the first case to consider the issue of active voluntary euthanasia was based on academic data which may help to explain the willingness of the court to take an accommodating view on the subject.

Another factor which has played some role in shaping legal outcomes concerns the Dutch legal system and the absence of a minimal level of punishment.³³³ This has left the courts free to impose very lenient sentences in cases where doctors have been brought before the courts for performing active voluntary euthanasia.

Evaluation of the Netherlands' Model: Suitability for Export?

It was suggested from the outset of this chapter that the Netherlands presents itself as a living model for other countries to assess the effects of State sanctioned active voluntary euthanasia upon the law, medicine, health care and social policy. It is therefore necessary to come to some conclusion about the position in the Netherlands and whether it is a model suitable for other countries to follow.

It is evident from the foregoing discussion that there are some problems with the present situation in the Netherlands. However, the problems which exist stem mainly from the fact that the administration of active voluntary euthanasia is still a criminal offence under the *Penal Code* 1886, and therefore its practice remains largely invisible and unregulated. It cannot, therefore, be extrapolated from the situation in the Netherlands that other countries contemplating the legalisation of active voluntary euthanasia through legislation would necessarily face the same difficulties.

In assessing the current situation in the Netherlands with regard to the practice of active voluntary euthanasia, we are greatly assisted by the recent surveys which have been conducted, in particular, the nation-wide survey of doctors conducted under the auspices of the Remmelink Committee. This survey indicated that the practice of active euthanasia in the Netherlands is in fact significantly less than had been previously estimated. Whilst there may be some scope for concern in view of the 0.8% of cases in which active steps were taken to terminate life without an explicit and persistent request from the patient, claims about the uncontrollable nature of euthanasia and the widespread practice of non-voluntary and even involuntary euthanasia have been shown to be unfounded. What the Netherlands experience has shown is that active voluntary euthanasia can be practised in accordance with the wishes of patients in a caring and humane way which, at the same time, respects the sensitivities of doctors.³³⁴ By and large, it appears that the contemporary practice of active voluntary euthanasia in the Netherlands is serving the interests of patients and there is no evidence of large scale

³³³ Verbal communication with Chief Prosecutor Jitta, November 1991.

³³⁴ M. Pabst Battin, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices' in Aycke and Smook, 124, 124.

abuses or extensions of the practice. Thus, it makes the option of an earlier death a reality for the small minority of patients that seek it, without causing any apparent harm or damage to society.

Even if the conclusion is reached that the contemporary practice of active voluntary euthanasia in the Netherlands is working satisfactorily, consideration must be given to the implications of the Netherlands situation for other countries, and the 'exportability of Dutch euthanasia practices'.³³⁵ In particular, care must be taken that a practice, operating satisfactorily in one country is not unthinkingly adopted in another, where, for a variety of reasons, it may operate quite differently.

Some attention has already been given to special features of Dutch society which may have contributed to the development of active voluntary euthanasia in that country. For the purposes of the present inquiry, consideration needs to be given to those aspects of the contemporary practice of active voluntary euthanasia in the Netherlands and Dutch society in general which may limit the applicability of the Dutch experience.

First, consideration must be given to a number of features of the Dutch health care system which appear to facilitate the performance of active voluntary euthanasia free from coercion or abuse. A significant feature of Dutch health care is the comprehensive scheme of national health insurance.³³⁶ The coverage of this insurance is in all cases substantial, including basic care as well costly high technology care.³³⁷ This is to be contrasted with the situation in some countries, such as the United States, where there is, at present, no national health care system or scheme of national health care insurance, and where a large number of people have no insurance at all or are substantially underinsured.³³⁸ Since the Netherlands has a health care system available to every citizen, there are not the same financial pressures on patients as there may be in some countries for the performance of active voluntary euthanasia.³³⁹

Another observation which has been made by commentators, from both within and outside the Netherlands, is that the medical establishment in the Netherlands as a rule is not commercially inclined³⁴⁰ and there are certainly no financial or other incentives for hospitals or doctors to terminate the lives of their patients.³⁴¹ Moreover, many have spoken of the integrity of the Dutch medical profession.³⁴²

³³⁵ *Id.* 124-136.

³³⁶ Battin, 'Seven Caveats Concerning the Discussion of Euthanasia in Holland', 76; Sneiderman, 108-109.

³³⁷ Dillmann, 8.

³³⁸ Pabst Battin, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices,' 127.

³³⁹ *Ibid.* See also C. Campbell, 'Aid-in-Dying' and the Taking of Human Life' (1992) 18 *J. Med. Ethics* 128, 133.

³⁴⁰ For example, Cohen, 62.

³⁴¹ Dillmann, 8.

³⁴² See, for example, the discussion in Aycke and Smook, 70-71.

Yet another special feature of the position in the Netherlands is that, as noted earlier,³⁴³ that country has a strongly developed system of general practice, with additional nursing care and other forms of care provided to the patient at home.³⁴⁴ The majority of patients die at home under the care of their family doctor. For those who are admitted to hospital or nursing homes, the Dutch pride themselves on uniformly high quality care with sufficient knowledge and skill in pain treatment and palliative care.³⁴⁵ Thus, a request for active euthanasia cannot be seen as an indication that inadequate care has been provided.³⁴⁶

It has been suggested that these elements of Dutch health care are important in that they constitute the social background for the practice of active voluntary euthanasia which is free from restraint and coercion.³⁴⁷ Whilst there are obviously difficulties in attempting to draw conclusions from the Dutch experience which may be applicable in other countries, consideration of these features suggests that the Dutch situation is not completely unique. In Australia, we have a national scheme of health insurance which ensures that health care is available to all. We too can boast high standards of medical care, with ever increasing knowledge and skill in pain treatment and palliative care. We also have a well established system of general practice, and there is no doubt about the overall integrity of our medical profession.

It should be noted that there are also a number of distinguishing features between the position in the Netherlands and other countries, such as Australia. The legal system in the Netherlands has its roots in Roman law and is, in the main, a civil-law orientated system.³⁴⁸ This contrasts with the situation in common law jurisdictions, such as Australia, which are derived from Anglo-Saxon law. However, as in Australia, Dutch judges are appointed for life³⁴⁹ and their independence is constitutionally guaranteed.³⁵⁰ There also appears to be some differences with regard to the role of the prosecuting authorities. In the Netherlands, there is considerable prosecutorial discretion, more so than in Australia or comparable jurisdictions.³⁵¹ Moreover, the prosecution in the Netherlands appears to occupy more of a policy-making role than is evident in other countries, and this is illustrated by the development of prosecution policy with regard to active voluntary euthanasia.³⁵² Indeed, it would be very difficult for other countries such as Australia to emulate the current position in the Netherlands, where cases of active voluntary euthanasia coming to the attention of the authorities are not prosecuted even though they are in breach of the criminal law.

³⁴³ See above, 397.

³⁴⁴ Dillmann, 8; Pabst Battin, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices,' 126; Sneiderman, 109.

³⁴⁵ Dillmann, 8.

³⁴⁶ Admiraal, 'Is there a Place for Euthanasia?' 15-16.

³⁴⁷ Dillmann, 8.

³⁴⁸ Sutorius, 'How Euthanasia was Legalised in Holland', 9.

³⁴⁹ Compare this, for example, with the situation in the United States where the judges are typically subject to public re-election; Pabst Battin, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices,' 127.

³⁵⁰ Sutorius, 'How Euthanasia was Legalised in Holland,' 9.

³⁵¹ *Id.* 10, Pabst Battin, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices,' 127. For discussion of Dutch prosecution policy see above, 359-360.

³⁵² Pabst Battin, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices,' 127.

Conclusion

The object of this chapter has been to examine the legal position and practice of active voluntary euthanasia in the Netherlands with a view to assessing the suitability of this model for adoption in Australia and other common law jurisdictions. The position which has been reached in the Netherlands with regard to active voluntary euthanasia is the product of a complex interplay which has taken place over the past two decades between the courts, prosecution policy and medical practice. Whilst it would be impossible to replicate this particular development elsewhere, valuable insight can be gained from examining the Dutch practice of active voluntary euthanasia which has at least gained *de facto* legal recognition. This in turn may be the basis for other countries such as Australia to introduce legislation providing some scope for the lawful administration of active voluntary euthanasia by doctors in carefully defined circumstances.

CHAPTER IX

OPTIONS FOR REFORM

Introduction

In earlier chapters, it has been suggested that there are various problems with the present law which call for a reassessment of the present legal prohibition of active voluntary euthanasia.¹ Consideration must now be given to possible legal responses to these difficulties to determine whether legislative reform is called for, and if so, what form it should take. Over the years quite a number of reform options have been advanced. The object of this chapter is to examine the various possible models for change and their respective merits and shortcomings, with a view to ascertaining the most appropriate model for reform.

Before embarking on consideration of possible options for reform, consideration needs to be given to one suggestion which has been made, but which does not in fact represent an option for change, namely that the most appropriate solution is to do nothing at all. This was, for example, the approach favoured by the Canadian Law Reform Commission in its review of the law with regard to active voluntary euthanasia.² The commission was of the view that the present criminal law prohibition of active voluntary euthanasia should be retained, but that the strictness of the law should continue to be ameliorated in individual cases through the internal mechanisms of the criminal justice system. This approach is said to have the advantage of recognising the appropriateness of active voluntary euthanasia in individual cases, yet avoiding the dangers and difficulties in drafting legislation to more formally accommodate the practice.³ However, as outlined in the earlier chapter dealing with the position in practice, this approach is subject to enormous problems.⁴ It inevitably produces uncertainty and does not adequately protect the position of either doctors or their patients. Moreover, toleration of the discrepancies which presently exist between the law on the books and the law in practice tends to lead to disrespect for the law. Some change to the present criminal law prohibition of active voluntary euthanasia is therefore required.

¹ See, in particular, chapter IV.

² Law Reform Commission of Canada, Working Paper No. 28, *Euthanasia, Aiding Suicide and the Cessation of Treatment* (1982) 51-52 (hereafter referred to as the Law Reform Commission of Canada, Euthanasia Working Paper); Law Reform Commission of Canada, Report No. 20, *Euthanasia, Aiding Suicide and the Cessation of Treatment* (1983) 19-20 (hereafter referred to as the Law Reform Commission of Canada, Euthanasia Report). See also H. Trowell, *The Unfinished Debate on Euthanasia* (1973) 143-144.

³ A. Browne, 'Assisted Suicide and Active Voluntary Euthanasia' (1989) 11 *Can.J.L.Juris.* 35, 50.

⁴ See chapter IV, 146-150.

Looking at the situation realistically, if there is going to be any change to the present law dealing with active voluntary euthanasia, it will have to be achieved through legislative action. Possibilities certainly exist for non-legislative solutions,⁵ and the situation in the Netherlands demonstrates that change can be achieved through the courts.⁶ However, in Australia and other jurisdictions under consideration, there is practically speaking, little scope for the courts to bring about reform⁷ and there are arguments to suggest that the legislature is, in any event, the more appropriate forum to bring about change in this area.⁸

Before going on to consider specific options for legislative reform, brief consideration must be given to the claims of some commentators that legalisation of active voluntary euthanasia would be contrary to international human rights instruments to which Australia is a party.⁹ Essentially the argument takes the form that the introduction of legislation would be contrary to Article 6 (para. 1) of the *International Covenant on Civil and Political Rights* 1976 which provides that 'every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.' However, as was argued in an earlier chapter,¹⁰ the right to life must be capable of being waived¹¹ and legislation permitting a doctor to administer active voluntary euthanasia would therefore not be an infringement of the individual's right to life. Thus, there is nothing in international human rights instruments which would prevent the introduction of legislation permitting active voluntary euthanasia.

Reform Options

It should be noted from the outset that the various reform options which have been advanced fall into two distinct categories: those which deal generally with 'mercy killings';¹² and those which are specifically confined to the performance of active voluntary euthanasia in the medical context.

⁵ For example, the suggestion of Professor Glanville Williams in his text *The Sanctity of Life and the Criminal Law* (1958) 284 that active voluntary euthanasia may in extreme circumstances be justified under the general doctrine of necessity. See also P. Mackinnon, 'Euthanasia and Homicide' (1983-84) *Crim.L.Q.* 483, 504-505; A. Rall, 'The Doctor's Dilemma: Relieve Suffering or Prolong Life?' (1977) 94 *S. African L.J.* 40, 46-48.

⁶ See chapter VIII, 356-367. Although Australian law provides for a defence of necessity it is highly unlikely that the judiciary would accept the defence in a case of active voluntary euthanasia. The courts would be inclined to take the view that such a momentous change in the law should come from the parliament. See also B. Sneiderman, 'Euthanasia in the Netherlands: A Model for Canada?' (1992) 8 *Humane Med.* 104, 106.

⁷ The opportunity for modification of the criminal law by the courts is even more circumscribed in those Australian jurisdictions where the criminal law is dealt with under a Criminal Code; see chapter I, n. 3.

⁸ D. Richards, 'Constitutional Privacy, the Right to Die and the Meaning of Life: A Moral Analysis' (1981) 22 *Wm. & Mary L.Rev.* 327, 418. See also *In re Farrel* 529 A.2d 404, 407-408 (1987) per Garibaldi J. for arguments regarding the advantages of legislative, as distinct from judicial, guidelines in matters of this nature.

⁹ See, for example, the view of the European Association of Centres of Medical Ethics regarding the resolution in favour of active voluntary euthanasia before the European Parliament; see Note, 'Euthanasia Vote Deferred' (1991) 70 *Bull.Med. Ethics* 6. Note also the minority view of the Dutch State Commission on Euthanasia; see chapter VIII, 374.

¹⁰ See chapter V, 200-201.

¹¹ See chapter V, 200.

¹² For a definition of mercy killing, see the Introduction to this thesis, 4.

Recognition of this distinction is important because it has implications with regard to the content and potential application of the respective proposals. Consideration will initially be given to options for reform falling within the first category dealing generally with mercy killing.

Mercy Killing

One possible direction for change would be to establish lesser penalties for mercy killing. This could be achieved in a number of ways including: 1) the creation of a separate offence for compassionate murder; 2) the introduction of a sentencing discretion allowing for the reduction, or even setting aside, of penalties in cases of homicide prompted by compassionate motives; or 3) the creation of a new defence which would reduce the offence from murder to manslaughter.

The first two proposals are similar to the position in a number of European countries, where the actor's motive is a critical factor in determining culpability.¹³ For example, in both Switzerland and Germany, compassionate killing does not come within the classification of murder but rather 'manslayer'.¹⁴ Moreover, in determining the appropriate punishment, the courts are required to take into account the defendant's motive which may justify a reduction in sentence.¹⁵ In circumstances where the killing took place at the victim's request, it falls within a separate category of 'homicide upon request' which attracts a lesser penalty than murder.¹⁶ These factors, either singly or in combination, operate to provide considerable leniency in the treatment of mercy killers in these jurisdictions.¹⁷

Consideration will now be given to the three possible options set out above.

The Creation of a Separate Offence for Compassionate Murder

As noted above, one possible option for change which has been suggested is to make some provision for compassionate murder or mercy killing by the creation of a separate offence with a lower penalty than for murder.¹⁸ This would enable the courts to take into account the motive of the defendant in determining liability. A proposal along these lines has been supported by a number of commentators

¹³ For an excellent discussion of the position under the German and Swiss Penal Codes, see H. Silving, 'Euthanasia: A Study in Comparative Criminal Law' (1954) 103 *U.Pa.L.Rev.* 350, 360-368. See also M. Sayid, 'Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland and the United States' (1983) 6 *B.C.Int'l. & Comp.L.Rev.* 533.

¹⁴ See Articles 211 and 212 of the German *Penal Code* and Article 63 of the Swiss *Penal Code*. For commentary, see Sayid, 550-552; Silving, 364-366.

¹⁵ See Article 213 of the German *Penal Code* and Article 64 of the Swiss *Penal Code*. See also discussion by Sayid, 551-553; Silving, 366-367.

¹⁶ See Article 216 of the German *Penal Code* and Article 114 of the Swiss *Penal Code* respectively. See also discussion by Sayid, 553-555; Silving, 378-386. It is to be noted that the *Penal Code* of Uruguay of 1933 provides for total exculpation where a homicide is motivated by compassion and performed upon the victim's own request; see Silving, 368-369.

¹⁷ See also Silving, 363.

¹⁸ There is also the alternative possibility of creating a specific offence of killing on request as is the case in Switzerland and Germany.

and agencies¹⁹ and has the advantage that the offender is charged with a specific offence other than murder and is liable to a lesser punishment.²⁰ Concern has, however, been raised about using motive as a criterion for liability.²¹ Whilst there are obviously difficulties involved in making motive an element of the offence, primarily with regard to proof, they are not insurmountable.²²

Sentencing Discretion

An alternative possibility would be to retain the existing legal prohibition but to allow the courts a discretion in sentencing to take into account the defendant's compassionate motive either to reduce or completely set aside penalties.²³ Questions arise as to the appropriate scope of such a sentencing discretion; whether it be confined to cases of compassionate killing or whether it should take the form of a more general sentencing discretion applicable in all cases of homicide.²⁴ Whichever form the sentencing discretion were to take, this proposal would provide some formal mechanism for the lenient punishment of persons who take life for compassionate motives. However, some unease has been expressed about this proposal on the grounds that, as with the aforementioned option, the court would be required to ascertain the defendant's motive.²⁵ Moreover, even if only a light punishment were imposed, the offender would still experience the stigma of a murder conviction.²⁶

A Defence Reducing Murder to Manslaughter

Another possible option for reform is to allow mercy killing to be a partial defence to murder.²⁷ The onus would rest upon the defendant to adduce evidence in support of the defence and if established, the defendant would be convicted of manslaughter rather than murder.

Some commentators have favoured one or more of the foregoing solutions on the grounds that they represent an appropriate compromise, acknowledging that cases of mercy killing are generally

¹⁹ For example, D. Meyers, *The Human Body and the Law* (1970) 155; J. Castel, 'Nature and Effects of Consent with Respect to the Right to Life and the Right to Physical and Mental Integrity in the Medical Field: Criminal and Private Law Aspects' (1978) 16 *AltaL.Rev.* 293, 323; F. Maher, 'Euthanasia' (1985) 59 *Law Inst.J.* 445, 447. A proposal for the creation of a separate offence was put forward by the English Criminal Law Revision Committee in its working paper on Offences Against the Person but the committee resiled from this position in its final report; see chapter VII, 322. A similar proposal was considered by the Royal Commission on Capital Punishment; see chapter VII, 321.

²⁰ Law Reform Commissioner Victoria, Working Paper No. 8, *Murder: Mental Element and Punishment* (1984) 27 (hereafter referred to as the Victorian Law Reform Commissioner, Working Paper).

²¹ Law Reform Commission of Canada, *Euthanasia Working Paper*, 48-49. (For criticism of the commission's reasoning see Browne, 52.) See also the Victorian Law Reform Commissioner, Working Paper, 27; and the *Royal Commission on Capital Punishment* (1953) Cmnd. Papers, 8932, para. 179.

²² For further discussion see the Victorian Law Reform Commissioner, Working Paper, 27.

²³ For consideration of this option, see the Victorian Law Reform Commissioner, Working Paper, 26-27; and the Law Reform Commission of Canada, *Euthanasia Working Paper*, 49-51.

²⁴ See, for example, the suggestion of J. Sander, 'Euthanasia: None Dare Call it Murder' (1969) 60 *J.Crim.L., Criminology & Police Science* 351, 358. In a number of jurisdictions consideration has been given to whether the penalty for murder should be at the discretion of the court. To date, this has been rejected in the United Kingdom, but in a number of Australian jurisdictions, the mandatory life sentence for murder has been abolished; see chapter IV, n. 140.

²⁵ See, for example, the discussion in the Law Reform Commission of Canada, *Euthanasia Working Paper*, 50-51.

²⁶ Victorian Law Reform Commissioner, Working Paper, 27.

²⁷ For consideration of this option see the Victorian Law Reform Commissioner, Working Paper, 27-28. See also B. Sneiderman, 'Why not a Limited Defence? A Comment on the Proposals of the Law Reform Commission of Canada on Mercy Killing' (1985) 15 *Man.L.J.* 85, 94-96.

considered less reprehensible than ordinary acts of homicide and therefore deserving of special treatment, yet not going so far as to formally endorse mercy killing by legalisation.²⁸ Whilst the implementation of any of these reforms would arguably be an improvement on the present unsatisfactory situation, these proposals are not the appropriate solution to the particular difficulties in the area of medically administered active voluntary euthanasia. The main objection to all of the foregoing proposals in the context of medically administered active voluntary euthanasia is that doctors remain at risk of criminal liability if they engage in the practice.²⁹ It may, admittedly, be a liability for some lesser offence than murder, or the penalty may be nominal, depending on which proposal is implemented and the form in which it is introduced. The fact remains, however, that doctors who perform active euthanasia at the patient's request would still potentially be exposed to criminal liability. One must bear in mind that these particular proposals were not intended to deal specifically with the issue of active voluntary euthanasia in the medical context but rather were directed generally at compassionate or mercy killings which may arise in a whole range of circumstances.³⁰ This accounts for the limited nature of these proposals, seeking simply to diminish the liability of the defendant, rather than providing a complete immunity from liability:

Mercy Killing as a Complete Defence?

A number of commentators have gone further and suggested stronger measures in the form of a complete defence to a charge of murder in circumstances where the defendant has acted out of compassionate motives. Rachels, for example, has suggested that a plea of mercy killing be acceptable as a defence against a charge of homicide in much the same way that a plea of self-defence is acceptable.³¹ Accordingly, someone charged with homicide could plead mercy killing - if it could be shown that the victim while competent requested death - and that the victim was suffering from a painful and terminal illness, the defendant would be acquitted.³² The onus would be on the mercy killer to present clear and convincing evidence that the patient was competent, terminally ill and voluntarily chose to die.

Although this proposal has the advantage of offering a doctor (and any other mercy killer) the possibility of a complete acquittal, it still falls short of legalisation. Active voluntary euthanasia performed by a doctor would still *prima facie* be unlawful as murder. It would be up to the doctor to raise the defence and a matter for the court to determine whether the defence should be accepted in a particular case. This proposal for a mercy killing defence does not, therefore, provide sufficient protection either to doctors or their patients with regard to medically administered active voluntary euthanasia.

²⁸ Silving, 388; Meyers, 155; Sneidman, 95-96.

²⁹ J. Wilson, *Death by Decision* (1975) 165 where he notes that a legal system that only reduces the penalty for active voluntary euthanasia is not sufficient to meet the problems of contemporary medical practice in terminal cases because it fails to provide adequate guidelines for the difficult life and death decisions that must be made in this context.

³⁰ See chapter IV, 129-146 for reference to some of the mercy killing cases.

³¹ J. Rachels, *The End of Life* (1986) 185. For analysis and support for Rachels' proposal, see W. Winslade, 'Guarding the Exit Door: A Plea for Limited Toleration of Euthanasia' (1988) *Hous.L.Rev.* 517, 520-523.

³² Rachels, 185.

Another proposal, which goes somewhat further has been put forward by Williams. In contrast to the other proposals considered above,³³ this particular proposal is specifically confined to active voluntary euthanasia administered by a medical practitioner.³⁴ On the basis of this proposal:

No medical practitioner should be guilty of an offence in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. Under this formula it would be for the physician, if charged, to show that the patient was seriously ill, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed to him by law.³⁵

This suggested formulation differs from that of Rachels in that it proceeds on the basis that it is lawful for a medical practitioner to terminate the life of a seriously ill patient and the onus would be on the prosecution to prove that the act was not done in good faith and with the consent of the patient. It therefore represents a form of legalisation of active voluntary euthanasia.³⁶ This proposal also has the advantage that it is specifically confined to medically administered active voluntary euthanasia and can consequently address the special needs in that area. Williams' proposal is nevertheless open to criticism on the grounds that it contains inadequate safeguards for the practice of active voluntary euthanasia. It affords doctors too much discretion in the matter and, as a result, does not provide sufficient protection for the patient.³⁷

The foregoing analysis has shown that proposals for reform which are directed generally at mercy killings are not the appropriate solution for the particular difficulties raised by the issue of active voluntary euthanasia in the medical context. This is because mercy killing performed by family or friends on the one hand, and medically administered active voluntary euthanasia on the other, are quite different in nature and raise quite distinct issues. Whilst there is a widespread desire to show leniency to mercy killers and avoid the hypocrisy which pervades the present application of the law, few would contend that such offenders should completely escape liability. In the medical context, however, where a doctor acts *bona fide* at the request of a patient and performs active euthanasia, there is a case to say that a doctor should be protected from incurring criminal liability, provided he or she has acted in accordance with acceptable criteria. The present problems which confront the law with regard to active voluntary euthanasia therefore require specialised attention and the discussion which follows will be confined to this area.

³³ See above, 404-406.

³⁴ See also H. Brody, 'Assisted Death - A Compassionate Response to Medical Failure' (1992) 327 *New Eng.J.Med.* 1384 where he puts forward a proposal for the creation of a defence to a charge of murder or assisted suicide in a genuine case of medically assisted death.

³⁵ Williams, 303.

³⁶ See below, 410-425 for further discussion of possible legislative models.

³⁷ See also Browne, 53. Indeed, Williams himself recognised that this proposal confers on the medical practitioner a wide discretion; Williams, 302. In fairness to Williams, however, it must be pointed out that this proposal was developed in response to the criticisms of some of the opponents of earlier measures for the legalisation of active voluntary euthanasia which had contained rigorous safeguards and procedures. See the *Voluntary Euthanasia (Legalisation) Bill* 1936 (U.K.); chapter VII, 318-319.

Significantly, many of the objections which have been raised against the various proposals for change with regard to compassionate or mercy killing do not apply with the same force to medically administered active voluntary euthanasia. For example, concerns have been raised about the difficulties in establishing the real motives behind a killing in circumstances where the killer may have acted out of mixed motive; i.e. partly motivated by compassion for the patient but also in part driven by a desire to put an end to a difficult family situation or to gain some material benefit from the patient's death.³⁸ More general concerns have also been raised about the possibility of abuse of any liberalisation of the law, with for example, *mala fide* murders being committed and disguised as compassionate murders.³⁹ It would be naive to suggest that legislative reform with regard to medically administered active voluntary euthanasia would be completely free of difficulties or risks. However, compared with the more general mercy killing scenario, it is reasonable to assume that doctors, operating under their professional codes of practice, are less likely to have some ulterior motive in hastening the death of the patient.

Doctor-Assisted Suicide

One possibility for reform with specific reference to the medical context is for the legalisation of doctor-assisted suicide.⁴⁰ Such a measure would provide legal protection to a doctor who, at the patient's request, provides the patient with the necessary assistance to commit suicide. There is, undeniably, a strong similarity between medically administered active voluntary euthanasia and doctor-assisted suicide, though under the law as it presently stands, the legal outcomes are markedly different.⁴¹ In canvassing possible options for reform, one possibility would be for the legalisation of doctor-assisted suicide *alongside* the legalisation of medically administered active voluntary euthanasia.⁴² Indeed, it would be strange if it were lawful for a doctor to take active steps to end a patient's life but could not in the same circumstances provide the patient with the means of taking his or her own life. The option being considered here, however, presupposes retention of the existing

³⁸ See, for example, the Law Reform Commission of Canada, Euthanasia Working Paper, 50-51. It should be noted, however, that the Canadian Law Reform Commission also raised specific concerns in connection with the legalisation of active voluntary euthanasia; see the Law Reform Commission of Canada, Euthanasia Working Paper, 44-48.

³⁹ Law Reform Commission of Canada, Euthanasia Working Paper, 51.

⁴⁰ This particular option is distinct from proposals for review of the law with regard to assisting suicide generally; see, for example, Law Reform Commission of Canada, Euthanasia Working Paper, 52-55, and the proposed amendment to the *Suicide Act* 1961 (Eng.) in England, pursuant to the *Suicide Act (Amendment) Bill* 1985. The object of the *Suicide Act (Amendment) Bill*, introduced by Lord Jenkins, was to make it a defence to any charge relating to counselling, aiding and abetting suicide under the *Suicide Act* that the accused acted on behalf of the person who committed suicide and in so acting behaved reasonably, with compassion and in good faith. The Bill was, however, unsuccessful. Note also the suggestion for a complete defence in cases of compassionate aiding and abetting suicide; J. Horder, 'Mercy Killings - Some Reflections on Beecham's Case' (1988) 52 *J.Crim.L.* 309. For the reasons outlined above, 406, a general provision of the kind suggested in these proposals would not be an appropriate solution to the special problems raised in the medical context.

⁴¹ See chapters I and III.

⁴² A law could be framed in such a way that both options would be available to a patient. Alternatively, legislation permitting active voluntary euthanasia could be based on the requirement that the patient is incapable of suicide and requires assistance to end his or her life.

prohibition on medically administered active voluntary euthanasia and envisages doctor-assisted suicide as the *only* legislative measure.

The possibility of legalisation of doctor-assisted suicide has been advanced by a number of commentators and organisations⁴³ and is seen by many as a preferable alternative to any change with regard to active voluntary euthanasia. A number of arguments have been put forward in support of this method of reform. An obvious advantage is that patients wishing to commit suicide would have the benefit of appropriate medical information and assistance in achieving that result. This would reduce many of the risks associated with patient suicide; for example, that the patient's diagnosis and prognosis are inadequately confirmed and that the means chosen for suicide will be unreliable or inappropriately used or may possibly fall into the wrong hands.⁴⁴ From a practical point of view, the implementation of this proposal of doctor-assisted suicide would require minimal change to existing law. All Australian jurisdictions have legislation dealing with assisted suicide which could easily be amended to allow for doctor-assisted suicide.⁴⁵ Achieving legalisation of medically administered active voluntary euthanasia would, in comparison, inevitably be more complicated. Another advantage which is claimed in respect of this particular option is that acceptance of doctor-assisted suicide would at least provide some guarantee of the voluntariness of the patient's decision.⁴⁶ One of the concerns often raised with regard to the legalisation of active voluntary euthanasia is the difficulty in ascertaining truly voluntary consent.⁴⁷ Where, however, the patient's death is precipitated by the patient's own act, (albeit with the doctor's assistance), there is some assurance that the patient genuinely desired death. Another consideration which is advanced in support of doctor-assisted suicide in preference to active voluntary euthanasia is that it minimises third party involvement in the patient's death. It is reasoned that where the patient is capable of performing the death inducing act, there is no justification for others to do what that patient can do for him or herself. Further, it is argued, by minimising the involvement of doctors one avoids placing the responsibility of killing on others, and avoids the possible risk of emotional trauma to the person who brings death.⁴⁸ Finally, proponents of doctor-assisted suicide point out that since this is a far less drastic proposal than the

⁴³ For an example of such a proposal, see the Bill proposed for the legalisation of physician-assisted suicide in New Hampshire, United States; see chapter VII, 343-344. A number of the voluntary euthanasia societies in Australia have put forward legislative proposals for the decriminalisation of doctor-assisted suicide. See, for example the 'Discussion Paper on Decriminalising Voluntary Euthanasia in South Australia', December (1989) published by the South Australian Voluntary Euthanasia Society (S.A.V.E.S.). Similar work has been undertaken by the voluntary euthanasia societies in Victoria and New South Wales. However, the ultimate aim of these societies is to secure legalisation of active voluntary euthanasia. See chapter VI, 240-243.

The concept of doctor-assisted suicide has also received support from quite a number of commentators: see, for example, R. Syme, 'A Patient's Right to a Good Death' (1991) 154 *M.J.A.* 203; R. Hare, 'Euthanasia: A Christian View' (1975) 6 *Philosophic Exchange* 43, 51; H. Smith, 'Termination of Life' (1971) *B.M.J.* 111; R. Crisp, 'A Good Death: Who Best to Bring It?' (1987) 1 *Bioethics* 74, 74-75.

⁴⁴ M. Battin, 'Euthanasia: The Way We Do It, The Way They Do It' (1991) 6 *Journal of Pain & Symptom Management* 298, 301.

⁴⁵ See, for example, the legislative proposals put forward in the S.A.V.E.S. 'Discussion Paper on Decriminalising Voluntary Euthanasia in South Australia.'

⁴⁶ Crisp, 75; J. Glover, *Causing Death and Saving Lives* (1984) 184; M. Heifetz with C. Mangel, *The Right to Die* (1975) 106.

⁴⁷ See chapter V, 207-209.

⁴⁸ Crisp, 75.

legalisation of active voluntary euthanasia, it is likely to enjoy wider acceptability amongst doctors and the community generally.⁴⁹

There is undeniably some substance to these claims. Indeed, these considerations may well justify a cautious approach to the legalisation of active voluntary euthanasia and could arguably justify the inclusion of a requirement that active voluntary euthanasia only be available in circumstances where the patient is physically unable to commit suicide.⁵⁰ Notwithstanding the advantages of this proposal for reform, it is not, on its own, a satisfactory legal response to the present problems with regard to medically assisted dying. Whilst the possibility of doctor-assisted suicide may be appropriate and adequate in many cases, it does not represent a complete solution to the present difficulties in this area. There will always be a proportion of patients who are physically unable to commit suicide.⁵¹ For others, the concept of suicide may for some reason be objectionable, yet they may willingly seek active voluntary euthanasia.⁵² If the legal response was limited to doctor-assisted suicide, these categories of individuals would not be provided for.⁵³

In the event that reform of the law were to take this particular course of allowing doctor-assisted suicide, careful consideration would have to be given to the appropriate method of securing such reform. In particular, it would be necessary to define the circumstances in which a doctor could lawfully assist the suicide of a patient; should a doctor be able to assist suicide only if there is a painful and incurable disease or should a doctor be able to assist any sane person who has determined to take his or her own life?⁵⁴ Similar problems of definition would of course also arise with attempts to legalise active voluntary euthanasia (and will be considered in more detail in that context), but in the area of suicide, special care would need to be taken to ensure that irrational suicide was not encouraged.⁵⁵

Legalisation of Active Voluntary Euthanasia

The most far-reaching legislative option for reform would be the legalisation of active voluntary euthanasia. Developing an appropriate model for the legalisation of active voluntary euthanasia will inevitably be a difficult and challenging task. That is, however, not a justifiable reason to avoid addressing the problems inherent in the present law and practice. It is beyond the scope of this thesis to present draft legislation for the legalisation of active voluntary euthanasia. Rather, the aim of this thesis is to critically examine various legislative options for the legalisation of active voluntary

⁴⁹ Syme, 204.

⁵⁰ See, for example, the suggestion of S. Wolhandler, 'Voluntary Euthanasia for the Terminally Ill and the Constitutional Right to Privacy' (1983-84) 69 *Cornell L.Rev.* 363, 382.

⁵¹ L. Schiffer, 'Euthanasia and the Criminal Law' (1985) 42 *U. Toronto Fac.L.Rev.* 93, 107.

⁵² See also the argument in chapter V, 216.

⁵³ See also Schiffer, 107 where she argues that this could even be construed as a form of discrimination against incapacitated people.

⁵⁴ H. Trowell, 'Suicide and Euthanasia' (1971) *B.M.J.* 275.

⁵⁵ See further chapter III, 99-100.

euthanasia and to make recommendations in more general terms, on appropriate legislative measures for the legalisation of active voluntary euthanasia.

An initial question which must be addressed is the approach which legislative reform should take. There are obviously a whole host of possibilities, ranging from very formal procedures, requiring judicial review of all euthanasia decisions⁵⁶ at one extreme, to a very simple legislative model with a minimum of safeguards and formality which vests an enormous discretion in the doctor.⁵⁷ As noted in a previous chapter,⁵⁸ over the years, quite a number of proposals have been put forward for the legalisation of active voluntary euthanasia. Some have actually taken the form of legislative initiatives,⁵⁹ others have been proposed by commentators in the campaign for legalisation.⁶⁰ The Netherlands model for the practice of active voluntary euthanasia is also an option upon which legislation could be based.⁶¹ Although the guidelines for the practice of active voluntary euthanasia in the Netherlands have been developed by the courts, as distinct from the legislature, the experience which has been gained in that country provides a valuable insight into the appropriate criteria and safeguards that legislation permitting active voluntary euthanasia should contain.

The dilemma inevitably faced in framing legislation for the legalisation of active voluntary euthanasia is striking the appropriate balance between the inclusion of adequate safeguards and procedures for the protection of both doctors and patients and, at the same time, avoiding excessive formality and bureaucratization of the procedures for active voluntary euthanasia which may ultimately defeat its efficient and humane administration.⁶² Proposals for legalisation which involve judicial review of the patient's request for active euthanasia, or the involvement of a 'euthanasia referee' or other official or body,⁶³ seek to provide for a formalised application procedure; the patient seeking active euthanasia

⁵⁶ See, for example, the early legislative proposals in the United States, in particular, the 1937 Nebraska Bill and the 1938 New York Bill for the legalisation of voluntary active euthanasia. The English *Voluntary Euthanasia (Legalisation) Bill* of 1936, upon which these United States Bills were largely based, proposed the use of a euthanasia referee, appointed by the Minister of Health; see chapter VII, 318. A number of commentators have also proposed a system of judicial review; e.g. J. Fletcher, 'Morals Medicine and the Law - Symposium: The Issues' (1956) 31 *N.Y.U.L.Rev.* 1157, 1159-1160 (see also J. Fletcher, *Morals and Medicine*, (1979) 187-188); A. Alschuler, 'The Right to Die' (1991) 141 *New L.J.* 1637. Note also C. Brandt *et al.*, 'Model Aid-In-Dying Act' (1989) 75 *Iowa L.Rev.* 125, 179-187 where the establishment of an 'Aid-in-Dying Board' is proposed.

⁵⁷ For example, Williams' proposal in *The Sanctity of Life and the Criminal Law*, 302-309.

⁵⁸ See, for example, chapter VII, 318-320 for discussion of the position in the United Kingdom.

⁵⁹ See, for example, the English *Voluntary Euthanasia (Legalisation) Bill* 1936 and the *Voluntary Euthanasia Bill* 1969, the Nebraska Bill of 1937 and more recently, the proposed physician aid-in-dying legislation in the United States. For fuller coverage of these legislative developments, see chapter VII.

⁶⁰ See, for example Williams' proposal in *The Sanctity of Life and the Criminal Law*, 302-309. Note also the model acts which have been suggested by S. Cole and M. Shea, 'Voluntary Euthanasia: A Proposed Remedy' (1975) 39 *Alb. L. Rev.* 826; W. Steele and B. Hill, 'A Plea for a Legal Right to Die' (1976) 29 *Okla.L.Rev.* 328; Brandt *et al.*, 'Model Aid-In-Dying Act'.

⁶¹ See chapter VIII.

⁶² Note Williams, *The Sanctity of Life and the Criminal Law*, 298-302 and G. Williams, 'Euthanasia' (1970) 63 *Proceedings of the Royal Society of Medicine* 659, 666 where he comments on the irony that legislation which provided for the legalisation of active voluntary euthanasia and contained stringent safeguards (the 1936 *Voluntary Euthanasia (Legalisation) Bill*) (U.K.) was criticised on the grounds that it would bring too much formality into the sickroom.

⁶³ For example, T. Helme, 'The Voluntary Euthanasia (Legalisation) Bill (1936) Revisited' (1991) 17 *J.Med. Ethics* 25, 27 where he suggests that a system of euthanasia tribunals be introduced. See further, T. Helme and N. Padfield, 'Safeguarding Euthanasia' (1992) 142 *New L.J.* 1335 where this suggestion is further developed. Note also the early suggestion made by the Australian Voluntary Euthanasia Society

brings an application or petition, together with supporting medical evidence, before the court or euthanasia official, and following an investigation of the case, and having regard to the criteria for active voluntary euthanasia under the enabling legislation,⁶⁴ a determination would be made as to whether the patient's request for active euthanasia should be granted. Proponents of this model for reform contend that the advantage of such a procedure is that there is an independent investigation of the circumstances and an objective determination as to the permissibility of active voluntary euthanasia. This, they claim, provides an important opportunity to ascertain the patient's decision-making capacity, the voluntariness of the patient's request, and other specified preconditions for the fulfilment of the euthanasia request.⁶⁵ However, legislative reform based upon a model of judicial review is subject to the criticism that it is a cumbersome procedure which unnecessarily bureaucratizes the handling of euthanasia requests.⁶⁶ There is also the argument that the courts (or similar bodies) are, in any event, not a suitable decision-making forum for euthanasia determinations.⁶⁷ The legitimate need to provide safeguards and to protect against abuse can be met without requiring judicial participation in the euthanasia procedure.⁶⁸ There is obviously a need for certain formal procedural requirements if active voluntary euthanasia is to be legalised,⁶⁹ but these must be kept to a minimum if we are to avoid them becoming a barrier to relief.⁷⁰

Consideration must now be given to the appropriate safeguards and criteria for the legalisation of active voluntary euthanasia.

Possible Safeguards for the Legalisation of Active Voluntary Euthanasia

Condition of the Patient

An initial question which arises is whether it is appropriate to have any reference to the condition of the patient as a precondition for eligibility for active voluntary euthanasia. This thesis has focussed on the contemporary understanding of euthanasia, i.e. euthanasia in the medical context in circumstances where the patient is suffering from some illness or disability,⁷¹ and it is in this area

(as it then was) for the use of a euthanasia commissioner. See Note, 'Euthanasia Commissioner' (1974) Vol. 1 No. 3 *A.V.E.S. Newsletter* 5. A number of commentators have also suggested the use of ethics committees to review patients' requests and authorise the performance of active voluntary euthanasia; e.g. J. Zaremba, 'Death with Dignity: Implementing One's Right to Die' (1987) 64 *U.Det.L.Rev.* 557, 572. The ethics committee concept has previously been suggested for determinations with regard to the withholding and withdrawing of treatment determinations; e.g. H. Hirsch and R. Donovan, 'The Right to Die: Medico-Legal Implications of In re Quinlan' (1976-77) 30 *Rutgers L.Rev.* 267, 273-276.

⁶⁴ See below, 412-425.

⁶⁵ Alschuler, 1638.

⁶⁶ M. Moore, 'The Case for Voluntary Euthanasia' (1972-1974) 41-42 *U.M.K.C.L.Rev.* 327, 338; A. Levisohn, 'Voluntary Mercy Deaths' (1961) 8 *J. Forensic Med.* 57, 79. Much also depends on the terms of the proposed legislation and whether it gives the relevant court, body or official a *discretion* to authorise active euthanasia; if so, it could be argued to constitute an unjustifiable restriction on the patient's capacity to request active euthanasia.

⁶⁷ Richards, 418.

⁶⁸ Moore, 339.

⁶⁹ In this regard, the proposal put by Williams referred to above, 407, confers too much discretion on physicians and does not provide adequate safeguards against abuse.

⁷⁰ R. Samek, 'Euthanasia and Law Reform' (1984) 17 *Ottawa L.Rev.* 86, 114.

⁷¹ See the Introduction to this thesis, 3-6.

that there are particular problems with law and practice which need to be addressed. On a very liberal view of self-determination it could be argued that all patients who have decision-making capacity, should be free to seek active euthanasia, regardless of their medical condition. However, if there were no requirements at all as to the condition of the person seeking active euthanasia, the spectre would be raised of suicide upon request, for whatever reason. The arguments which have been developed in this thesis have proceeded on the basis that only in exceptional circumstances is there justification for creating an exception to the normal criminal prohibition on the taking of life.⁷² The justification for permitting active voluntary euthanasia is therefore only established in cases where the person requesting euthanasia is suffering from some serious condition which he or she finds intolerable. Aside from these considerations, there is an additional argument in support of confining the class of candidates for active euthanasia in the interests of minimising the potential for abuse and mistake.⁷³ Thus, on the assumption that it is both necessary and appropriate to include some reference to the patient's condition in the eligibility criteria for active voluntary euthanasia,⁷⁴ consideration will now be given to possible preconditions which could be imposed.

A number of the legislative proposals have proceeded on the basis that the patient must be in a 'terminal' state before the patient is eligible for active voluntary euthanasia.⁷⁵ Proposals of this kind are fairly limited in their application and would not permit active voluntary euthanasia in respect of an incurable and suffering patient who is not expected to die from his or her condition.⁷⁶ There are also problems in the application of this requirement (particularly where terminal illness is defined by reference to a specified period of time⁷⁷) because of the notorious difficulties in accurately predicting a terminal patient's life expectancy.⁷⁸

⁷² See chapter V, 227-228.

⁷³ See Browne, 54-55 where he argues that the question of who should be eligible for assisted death cannot simply be settled by reference to who has a good reason for death but must also take into account the potential for abuse and mistake to which the legislation gives rise.

⁷⁴ For an example of a proposal for voluntary euthanasia legislation which deliberately does not contain any limitation as to the condition of the patient, see Steele and Hill, 343.

⁷⁵ The word 'terminal' is open to a number of possible interpretations; for example, under the 1988 Californian initiative for physician aid-in-dying, the *Humane and Dignified Death Act*, 'terminal condition' was defined as one which is incurable and with reasonable medical certainty will lead to death within six months. A similar definition was contained in the Washington Initiative 119. See chapter VII, n. 348. However, 'terminal' could be more broadly defined to refer to any incurable condition, whether or not death is actually impending; see, for example the proposal put forward by Cole and Shea, 839 where terminal illness or injury is defined as any illness or injury that is reasonably certain to result in the expiration of life, regardless of the use of medical treatment and which illness or injury has reached a stage at which painful or debilitating symptoms are imminent. Other proposals, including the 1936 *Voluntary Euthanasia (Legalisation) Bill* in the United Kingdom, refer to an 'incurable and fatal disease involving severe pain'. See also Fletcher, 'Morals Medicine and the Law - Symposium: The Issues,' 1159.

⁷⁶ Indeed, it could be argued that provided pain is adequately controlled, the terminally ill patient is less likely to need active voluntary euthanasia than someone whose equally distressing illness or disability is not terminal, since the latter could face many years of suffering; see B. Smoker, 'Remember the Non-Terminally Ill and Disabled' (1991) 43 V.E.S. *Newsletter* 10. In the Netherlands, the requirement of a terminal illness was rejected in the early stages of the Dutch jurisprudence on the subject; see chapter VIII, 366.

⁷⁷ For example, under the Californian *Humane and Dignified Death Act* see above, n. 75.

⁷⁸ For criticism of the terminal illness requirement, see chapter VII, 331.

An alternative possible criterion which has been advanced in some of the legislative proposals, is that the patient's condition must be incurable.⁷⁹ This is less restrictive, since, by definition, the patient need not actually be dying, but simply have a condition which cannot be cured. On the basis of this requirement, the field of potential candidates for active voluntary euthanasia would be significantly expanded. For example, a quadriplegic or a person suffering from some degenerative disorder such as multiple sclerosis, Parkinson's or Alzheimer's disease would be potentially eligible for active voluntary euthanasia. Incurability as a criterion would be preferable to the requirement of a terminal illness because it is less arbitrary and uncertain in its application and leaves greater scope to the patient to determine whether active voluntary euthanasia is an appropriate option.⁸⁰ One danger, however, of adopting incurability as the criterion, as distinct from a terminal condition, is that it may result in requests for active euthanasia by persons whose condition although incurable, is quite trivial. This possibility could be countered by an additional requirement that the condition of which the patient complains must be objectively serious.⁸¹

Under the Netherlands criteria, the requirement regarding the condition of the patient is even more permissive, simply requiring that there must be 'physical or mental suffering which the sufferer finds unbearable'.⁸² This clearly implies that the patient's suffering stems from a physical or mental condition but there is no stipulation as to the nature or seriousness of that condition. Moreover, the measure of suffering is to be determined subjectively, by reference to what the patient finds unbearable. This formulation has the advantage of conceptual simplicity and avoids the need to determine the state of the patient's condition (whether it be 'terminal' or 'incurable'.) It does, however, represent an expansion of potentially eligible candidates for active voluntary euthanasia; theoretically, any physical or mental condition would suffice, provided that it causes unbearable suffering to the patient. Although there is no evidence from the Dutch case law that this criterion causes difficulties in practice, it is conceivable that a person with a relatively minor physical condition or impairment, such as a skin disorder, seeks active euthanasia on the grounds that that condition causes him or her unbearable suffering. It is therefore recommended that in framing legislation for the legalisation of active voluntary euthanasia, a somewhat stricter and more objective requirement be imposed with regard to establishing the condition of the patient. The Netherlands criterion is, however, useful in focussing attention on the patient in determining the degree of suffering for the patient. Because of

⁷⁹ See, for example, the *Voluntary Euthanasia Bill* 1969 (U.K.) which had substituted the requirement of an 'irremediable' condition for the requirement of a 'fatal' condition contained in the 1936 *Voluntary Euthanasia (Legalisation) Bill* (U.K.). 'Irremediable' condition was defined under the legislation as a serious physical illness or impairment reasonably thought in the patient's case to be incurable and expected to cause him severe distress or render him incapable of rational existence; see chapter VII, 318-319. Note also H.B. 342 of the Hawaii Legislature (1975) which specified that a patient only need be suffering from an incurable physical illness which is causing him severe distress; see Browne 54.

⁸⁰ L. Carl, 'The Right to Voluntary Euthanasia' (1988) 10 *Whittier L.Rev.* 489, 548. This was also the view taken by the Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death; see chapter VII, 323.

⁸¹ For example, S. O'Brien, 'Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle Into That Good Night' (1987) 31 *St. Louis U.L.J.* 599, 665 where she refers, with approval, to the suggested criteria that the 'health of the suicide beneficiary is permanently, implacably and seriously impaired.'

⁸² See chapter VIII, 359. There is an additional requirement that 'the suffering and the desire to die must be lasting' (see chapter VIII, 359) however, this is not tantamount to requiring that the patient's condition be incurable.

the impossibility of objectively quantifying the degree of suffering that a patient experiences as a result of a particular condition, the assessment of this criterion must inevitably be subjectively assessed.

Some proposals for legalisation also refer to the presence of pain as an additional requirement alongside other preconditions.⁸³ There are, however, problems with this requirement. Apart from the fact that the presence or extent of pain that a patient is experiencing is impossible to gauge objectively, it could be argued that the reference to pain is, in any event, inappropriate. With the development of palliative care, the situation has now been reached where most pain can be relieved.⁸⁴ Moreover, experience has shown that the presence of pain is rarely of itself a reason for a patient to request active euthanasia.⁸⁵ It is therefore recommended that pain not be included as a specific criterion.

A difficult question which arises with regard to eligibility for active voluntary euthanasia concerns the status of mental disorders. The more expansive proposals for the legalisation of active voluntary euthanasia have extended eligibility to persons suffering from certain organically based mental disorders,⁸⁶ and it could be argued that this category should be extended even further to include all mental illnesses which cause the person severe distress.⁸⁷ Under the Netherlands criteria for example, active voluntary euthanasia is potentially available to all patients who are experiencing 'physical *or* mental suffering which the sufferer finds unbearable'.⁸⁸ An obvious difficulty when considering mentally impaired patients is their capacity to voluntarily request active euthanasia. Whilst some forms of mental impairment are permanent and would render a patient permanently incompetent, there are other mental conditions, such as certain forms of depression and anxiety, from which a patient may suffer only intermittently. The question then arises as to whether a patient who suffers from some form of irremediable mental impairment, but presently has decision-making capacity, should be eligible for active voluntary euthanasia. There appears to be no reason in principle why such persons should be excluded, simply because they suffer from a mental, rather than a physical condition. Indeed, it has been officially recognised that there is no necessary correspondence between mental illness and the presence or absence of decision-making capacity either in fact or in law.⁸⁹

⁸³ See, for example, the Bill introduced into the New York State legislature in 1938 which referred to a person suffering from 'severe physical pain caused by a disease for which no remedy affording relief or recovery is at the time known to medical science'; for discussion, see Wilson, 159. See also the proposal put by Fletcher 'Morals Medicine and the Law - Symposium: The Issues,' 1159 where he refers to a person suffering from 'an incurably painful and fatal disease.'

⁸⁴ See chapter V, 214.

⁸⁵ This is the view of Dr. P. Admiraal and the experience of other doctors in the Netherlands; verbal communication, Nov./Dec. 1991.

⁸⁶ See, for example, the H.B. 137 (1973) and H.B. 256 (1975) of the Montana Legislature and H.B. 143 of the Idaho Legislature (1969) which include reference to mental impairment provided that it is founded in a condition of 'brain damage or deterioration'; see Browne, 54.

⁸⁷ Browne 54.

⁸⁸ Author's emphasis. See chapter VII, 366 for reference to a recent case in which the Dutch courts accepted the doctor's argument that the mental suffering of a patient could be the basis for the defence of *noodtoestand*.

⁸⁹ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forgo Life-Sustaining Treatment* (1983) 123.

However, extra care would obviously need to be taken in such cases in ascertaining the patient's decision-making capacity and the voluntariness of the patient's request.

The eligibility criteria for the legalisation of active voluntary euthanasia should comprise a twofold test: first, that the person requesting active euthanasia has a serious and incurable physical or mental condition, (to be objectively assessed and documented by medically qualified persons); second, that that condition causes suffering intolerable to the patient. An additional requirement which could be included is that the suffering cannot be relieved or mitigated by other means. The advantage of this requirement would be to ensure that all other options have been explored, including the provision of palliative care, thus reinforcing that active voluntary euthanasia should only be available as a last resort. However, if we are to avoid undermining the patient's autonomy, this additional requirement is only acceptable if it is determined by reference to the patient's wishes; i.e. framed in terms that there are no alternatives *acceptable to the patient*. This is the approach which has been taken under the Netherlands criteria.⁹⁰ The criteria proposed here regarding the condition of the patient could readily be embodied in legislation for the legalisation of active voluntary euthanasia. They are sufficiently clear and understandable to provide a workable basis for eligibility. Moreover, there is no reason to believe that creating eligibility for active voluntary euthanasia in these circumstances (and subject to other criteria being fulfilled) would result in an expansion of categories over time as some opponents have alleged.⁹¹

One particular issue warranting consideration is whether pregnant women should be excluded from eligibility for active voluntary euthanasia.⁹² In a number of the proposals for the legalisation of active voluntary euthanasia, pregnant women are expressly exempted from eligibility⁹³ and this has raised opposition from supporters of the rights of women.⁹⁴ Significantly, these proposals have emanated from the United States where the State is recognised as having a compelling interest in preserving the life of the fetus, once the fetus becomes 'viable'.⁹⁵ In Australia, however, an unborn child has no legal rights separate from its mother,⁹⁶ so there would be no legal impediment to permitting a pregnant woman, who in all other respects meets the eligibility criteria, from seeking and being given active euthanasia.⁹⁷ Whether, as a matter of policy, it is appropriate to exclude

⁹⁰ See chapter VIII, 359.

⁹¹ See chapter V, 202-205.

⁹² For discussion, see, for example, Cole and Shea, 845-847. Note also the position with regard to living will legislation; see chapter VII, 329.

⁹³ For example, under the *Humane and Dignified Death Act* proposed in California, discussed by R. Risley, 'What the Humane and Dignified Death Initiative Does' (1986) 1 *Euthanasia Rev.* 221, 224) and the proposal of Cole and Shea, 845-847 where a female who is 20 or more weeks pregnant, and who, with reasonable certainty could survive to deliver a child, is excluded from the definition of a 'qualified person.'

⁹⁴ For a critical discussion of the issues see Carl, 549-550.

⁹⁵ *Roe v Wade* 410 U.S. 113 (1973).

⁹⁶ *F and F* [1989] F.L.C. 92-031; *Attorney-General for the State of Queensland (Ex rel. Kerr) and Anor v T* (1983) 57 A.L.J.R. 285, 286.

⁹⁷ Note, however, the recent English case of *Re S* (High Court Transcript, October 13 1992) in which a pregnant woman, carrying a viable fetus was forced to undergo an emergency caesarean against her wishes to save the life of the fetus. For criticism of this decision see D. Morgan, 'Whatever Happened to Consent?' (1992) 142 *New L.J.* 1448. This ruling was influenced by comments made by Lord Donaldson M.R. in *Re T* (Court of Appeal Transcript, July 30 1992) where, whilst upholding the right

pregnant women from eligibility is of course a separate matter. In the interests of protecting the autonomy of the patient, as well as keeping the legislation as streamlined as possible, it is recommended that no such limitation be included in any legislative reform. There would, in any event, be significant difficulties in the application of any such requirement.⁹⁸

In the context of the earlier discussion regarding medically assisted suicide, the possibility was noted of confining the option of active voluntary euthanasia to patients who are physically unable to commit suicide.⁹⁹ Whilst there may be some advantages attached to such a proposal, on balance, it would be an unjustifiable restriction on access to medically administered active voluntary euthanasia. As noted earlier, some people may find the concept of suicide objectionable, yet would willingly avail themselves of the option of medically administered active euthanasia.¹⁰⁰ To require patients who seek death to be actively involved in the bringing about of that death does not, in all the circumstances, seem warranted.

Voluntariness of the Patient's Request

It has been argued in an earlier chapter, that the principle justifications for permitting active voluntary euthanasia rests upon the notions of consent and self-determination.¹⁰¹ Ascertaining the voluntariness of the patient's request is, therefore, of the utmost importance in the decision to administer active voluntary euthanasia. It would accordingly be appropriate for any legislation permitting active euthanasia to require clear and convincing evidence that the patient genuinely wants active euthanasia and that the patient has made that request free from coercion and pressure from others.¹⁰²

There are a number of preconditions which are connected with the voluntariness of the patient's request.¹⁰³ First, the patient must have decision-making capacity of a level commensurate with the

of a competent adult to refuse medical treatment, he left open the question whether it was appropriate for a court to intervene in circumstances where the decision of a pregnant woman to refuse medical treatment, would effect the life of a viable fetus. For further discussion, see chapter II, 44.

⁹⁸ For example, how would the limitation be framed? Would it, as Cole and Shea suggest, be limited to circumstances where the woman could with reasonable certainty survive to deliver a live child or would it also apply in circumstances where the woman is not expected to survive the normal period of gestation?

⁹⁹ See above, 410.

¹⁰⁰ See above, 410.

¹⁰¹ See chapter V, in particular, 179-187, 222-228.

¹⁰² It should be noted that some proposals for legalisation of active euthanasia provide for a euthanasia decision to be made on behalf of the patient in circumstances where the patient is incompetent; e.g. Florida H.B. 3184 (1969); Montana H.B. 137 (1973); Oregon H.B. 2997 (1973); Wisconsin S.B. 670 (1971); see Cole and Shea, 837, n. 80. Note also the legislation proposed by P. Small, 'Euthanasia - The Individual's Right to Freedom of Choice' (1970) 5 *Suffolk U.L.Rev.* 190, 205; Steele and Hill, 343-346; Brandt *et al.* 163-174. Although providing a different mechanism, note should also be made of the Californian *Humane and Dignified Death Act* and the more recent legislative proposal for California, the *Death with Dignity Act*, which make provision for the appointment of a durable power of attorney with the power to seek aid-in-dying on behalf of a formerly competent patient. See chapter VII, 343.

¹⁰³ One possible precondition which could be imposed is that the request for active euthanasia must originate from the patient and must not be the product of suggestion by any other person. Although such a requirement might provide some assurance that the patient's request is voluntary, it would appear to be somewhat limiting. Circumstances can readily be envisaged where a doctor *bona fide* discusses options with the patient, including the possibility of an early release from suffering by the administration of active euthanasia and once informed of the possibility, the patient genuinely and

gravity of the decision. The patient's decision-making capacity should be assessed professionally, either by the patient's attending doctor, or if thought necessary, by a psychiatrist.¹⁰⁴ Second, in view of the seriousness and finality of active voluntary euthanasia, it is appropriate to impose an age limitation, such that only an adult, (i.e. a person over the age of 18 years) is eligible for its administration.¹⁰⁵ Third, the patient's decision to request active euthanasia must be an informed one. In order for the patient to make an informed choice the patient must be given full information about his or her condition and prognosis including any element of uncertainty in diagnosis or prognosis.¹⁰⁶ Full disclosure is essential to the unfettered exercise of the right to self-determination.¹⁰⁷ This requirement features prominently in the Netherlands criteria which require that: the decision to die must be the voluntary decision of an informed patient; that the patient must have a correct and clear understanding of his or her condition and of other possibilities (the results of this and that treatment and of no treatment); that the patient must be capable of weighing those options and must have done so. Fourth, the patient's request for active euthanasia must be durable. Here again, the Netherlands criteria are instructive, with the inclusion of the requirement that the patient's desire to die must be lasting. The durability of the patient's request can be confirmed by requiring that the request be repeated over an extended period of time before it is acted upon.¹⁰⁸ This would ensure that there is ample opportunity for the patient to reflect upon his or her decision. It also provides some guarantee that the patient's request for active euthanasia is made earnestly and is enduring and not the product of a hasty and ill conceived decision. A related requirement is that the patient must be given the opportunity to revoke the request at any time, regardless of the patient's physical or mental condition.¹⁰⁹ Fifth, provided the patient's decision is voluntary and made free of coercion, and the patient has satisfied the other relevant criteria for a euthanasia request, the patient's reasons or motive for making that decision should be irrelevant.¹¹⁰ There should be no additional requirement that the patient's decision is objectively reasonable. Finally, certain formalities with regard to evidencing patient consent are essential. The patient's request for active euthanasia should be in writing and

voluntarily wishes to proceed with this option. This practice occurs in the Netherlands and is accepted as active voluntary euthanasia; see chapter VIII.

¹⁰⁴ Wolhandler, 381 suggests that two independent psychiatric opinions must confirm the patient's competence. See also G. Benrubi, 'Euthanasia: The Need for Procedural Safeguards' (1992) 326 *New Eng.J.Med.* 197, 198. Some commentators assume that the treating doctor confirms both the patient's medical condition and the patient's mental competence; e.g. Samek, 115. For a discussion as to whether a psychiatric evaluation should be necessary in all cases, see Carl, 544-546.

¹⁰⁵ This requirement has appeared in a number of the legislative proposals; see, for example, the *Humane and Dignified Death Act* proposed in California and the Washington Initiative 119 (see chapter VII, 339-342) which refer throughout to an 'adult' person, and the 1936 and the 1969 voluntary euthanasia Bills proposed in the United Kingdom dealing with persons over the age of majority, (then 21 years of age); see chapter VII, 318-319. It should be noted that in some of the proposals for active voluntary euthanasia, the right to be euthanased has been extended to all persons capable of choosing such a course of action regardless of age; e.g. Cole and Shea, 847-849. Note also the euthanasia Bill introduced into the Wisconsin Legislature (H.B. 1207) which allowed for a person of seven years of age to request active euthanasia; see Browne, 54.

¹⁰⁶ J. Arras, 'The Right to Die on the Slippery Slope' (1982) 8 *Social Theory & Practice* 285, 301-302.

¹⁰⁷ Wolhandler, 382.

¹⁰⁸ See, for example, A. Morris, 'Voluntary Euthanasia' (1970) 45 *Wash.L.Rev.* 239, 267 where he suggests that a request for active euthanasia should come into force 30 days after being made. Note, however, the criticism of this requirement by Moore, 339.

¹⁰⁹ Arras, 300.

¹¹⁰ Wolhandler, 380.

signed by the patient.¹¹¹ Further, the request should be witnessed by two independent witnesses, who can testify that to the best of their knowledge, the patient is acting voluntarily and in an informed manner. Although these requirements may attract the criticism of excessive formality, they are important safeguards in the active euthanasia procedure.¹¹² If a patient is required to make his or her request in writing, it is more likely to be the product of serious thought and reflection. Moreover, a written request for active euthanasia constitutes evidence of a patient's voluntary request and thereby provides some protection to both patients and to doctors performing active euthanasia. A number of commentators have suggested that the procedural requirements for the legalisation of active voluntary euthanasia should include written proof of the patient's medical condition and of the patient's decision-making capacity to request euthanasia from the attending doctor.¹¹³ This would appear to be a prudent requirement ensuring that there be verification with regard to these key matters.¹¹⁴

The foregoing requirements and safeguards are all designed to ensure that the patient has decision-making capacity and that the patient's choice is fully informed and voluntary and accordingly represents a true exercise of patient self-determination.¹¹⁵

Status of Advance Directives and Other Mechanisms for Future Consent

A difficult question which must be addressed in framing any legislation for the legalisation of active voluntary euthanasia concerns the possible role of advance directives or living wills¹¹⁶ and other mechanisms for future consent such as the enduring power of attorney.

Considering first of all the use of advance directives, the question which must be addressed is whether a patient's request for active euthanasia in such a document, made at a time when the patient had decision-making capacity, should be recognised as a voluntary request, empowering a doctor to perform active euthanasia provided the other eligibility criteria are satisfied. Some of the legislative proposals for the legalisation of active voluntary euthanasia have made provision for the use of advance directives or living wills.¹¹⁷ For example, the 1969 *Voluntary Euthanasia Bill* proposed in

¹¹¹ Although a signed request from the patient is not included in the criteria developed by the courts in the Netherlands, it is one of the requirements under euthanasia protocols adopted by some of the hospitals. See chapter VIII, 371.

¹¹² One suggestion which has been made which goes even further, is for the video recording of voluntary euthanasia decisions. See B. Mettyear, 'Video Recording as a Safeguard in V.E.' (1991) Vol. 8 No. 4 *S.A.V.E.S. Bull.* 5.

¹¹³ For example, Samek, 115. The various proposals for a judicial hearing for the investigation of euthanasia requests also included a requirement of written evidence from the physician(s). See, for example the 1936 and 1969 voluntary euthanasia Bills proposed in the United Kingdom; see chapter VII, 318-319.

¹¹⁴ In framing the legislation, it would be advisable to avoid imposing on doctors an absolute standard of certainty in determining patient decision-making capacity, diagnosis, prognosis etc.; see Cole and Shea, 840-841 for reference to their proposed Bill which imposes 'reasonable certainty' as the criterion of liability.

¹¹⁵ D. Brock, 'Voluntary Active Euthanasia' (1992) 22 *Hastings Center R.* 10, 20.

¹¹⁶ See chapter VII for analysis of developments in Australia and other jurisdictions with regard to advance directives or living wills as a mechanism for refusing medical treatment.

¹¹⁷ For example, the 1969 *Voluntary Euthanasia Bill* (U.K.) and the proposals under the Californian initiatives for physician aid-in-dying (the 1988 *Humane and Dignified Death Act* and the *Death with Dignity Act* proposed for the 1992 referendum.); see chapter VII, 319 and 339-341, 343. Note also the proposals suggested by Morris, 266-271 (based on the 1969 U.K. Bill); Wolhandler, 381; Brandt *et al.*, 147-162.

the United Kingdom made provision for persons to request in advance the administration of active euthanasia in the event of their suffering from an irremediable condition.¹¹⁸ Under such proposals, the advance declaration only comes into effect if the patient no longer has the decision-making capacity to express his or her wishes.

There are a number of competing considerations which must be carefully weighed in determining whether advance directives should be recognised in this area. Recognition of some form of advance directives would have the advantage of maximising patient autonomy by enabling patients to indicate their wishes in advance in the event that they have a terminal or incurable condition and no longer have the decision-making capacity to request active euthanasia. This would, in turn, provide considerable reassurance to many patients.¹¹⁹ There are, however, serious problems inherent with advance directives or living wills, particularly where they make provision for active voluntary euthanasia.¹²⁰ As noted earlier, the voluntariness of the patient's request is fundamental to any proposal for reform of active voluntary euthanasia.¹²¹ Although a patient's advanced request for active euthanasia expressed in a document of this kind does constitute a form of consent, it is undeniably not as certain and reliable as the request of a patient expressed at the time of the patient's condition, repeated over a period of time and which is capable of verification. It is certainly true that legislation permitting active voluntary euthanasia could impose requirements to establish the voluntariness of the patient's request at the time the directive or living will is executed. There is, however, no guarantee that this request continues to accord with the wishes of the patient once he or she loses decision-making capacity. Moreover, since advance directives inevitably involve some speculation about future circumstances, it is simply not feasible for a patient to make an informed decision about a hypothetical future condition.¹²² As a result, advance directives entail an increased risk that decisions are made which do not in fact accord with the patient's wishes. Further, since there is no practical means of confirming the voluntariness of the patient's decision at the time the decision is to be acted upon, there is also a greater risk of abuse.

For the same reasons, the possibility of empowering a health care power of attorney or other agent to choose active euthanasia on one's behalf in the event of loss of decision-making capacity must also be rejected.¹²³ The legalisation of active voluntary euthanasia is a serious undertaking and any

¹¹⁸ See cls. 2(1) and (2). Under these provisions, a declaration signed by an adult and re-executed within 12 months would remain in force for life unless revoked. Note also the terms of the proposed legislation under the Californian initiatives for physician aid-in-dying which make provision for the appointment of a durable power of attorney, with the power to seek aid-in-dying on behalf of a formerly competent patient. See chapter VII, 339-341, 343. The Euthanasia State Commission in the Netherlands also recommended reliance on an advance directive in certain specified circumstances. See chapter VIII, 374.

¹¹⁹ For general commentary regarding the benefits of advance directives (in the context of refusal of treatment) see the Age Concern Institute of Gerontology and Centre of Medical Law and Ethics, *Living Will, Working Party Report* (1988) 46-47. See also D. Lanham and B. Fehlberg, 'Living Wills and the Right to Die with Dignity' (1991) 18 *Melbourne U.L.Rev.* 329, 331-335.

¹²⁰ For consideration of some of the general problems with living will legislation see chapter VII, 331-333.

¹²¹ See above, 417.

¹²² This was also the view of the Missouri Supreme Court in *Cruzan v Harmon* 760 S.W. 2d 408, 417 (1988).

¹²³ See chapter VII for coverage of this mechanism in the context of refusal of treatment decisions. Note also the 1988 Californian proposal, under the *Humane and Dignified Death Act* which provided for a

proposal for reform should therefore err on the side of caution. So, despite the undoubted benefits of advance directives and other mechanisms for having health care decisions made on behalf of patients who lack decision-making capacity, legislation providing for active voluntary euthanasia must be limited to patients who presently have decision-making capacity and who personally request active euthanasia because of a current condition. The decision to seek active euthanasia requires a level of self-determination which can only be exercised by individuals acting on their own behalf. This does, admittedly, significantly confine the availability of active voluntary euthanasia but this is necessary in order to ensure that the patient's request is truly voluntary and informed and to minimise the risk of error and abuse.¹²⁴

The Role of the Doctor

Doctors will inevitably have some role to play in the event that active voluntary euthanasia is legalised. Verification of a number of the eligibility criterion for the performance of active voluntary euthanasia discussed above,¹²⁵ necessarily rely on the participation of the medical profession.¹²⁶ First, a determination must be made as to the patient's decision-making capacity. Although the decision-making capacity of the patient could, in many cases, conceivably be determined by someone *other* than a doctor, on balance, doctors are probably the most appropriate persons to make this assessment and in difficult cases, the expert knowledge of psychiatrists, and or psychologists, would in any event need to be called upon. Second, medical knowledge is required to determine the condition of the patient (physical or mental) and to provide information to the patient about diagnosis, likely prognosis and available medical options.

One of the major arguments which has been advanced by opponents of active voluntary euthanasia relates to the difficulties in ascertaining patient decision-making capacity and the voluntariness of the patient's request.¹²⁷ Euthanasia opponents have also focused attention on the risks of mistaken diagnosis or prognosis.¹²⁸ An important safeguard to minimise the risks of error or abuse is the involvement of an independent doctor to verify the patient's decision-making capacity and the voluntariness of the patient's request and to confirm the diagnosis and prognosis of the patient's condition.¹²⁹ Significantly, under the guidelines for active voluntary euthanasia applicable in the Netherlands, consultation with another doctor is considered to be an important factor.¹³⁰ It is therefore recommended that legislation for the legalisation of active voluntary euthanasia should

nominated power of attorney to seek aid-in dying on behalf of the patient, subject to the review of a three person ethics committee; see chapter VII, 340.

¹²⁴ M. Angell, 'Euthanasia' (1988) 319 *New Eng.J.Med.* 1348, 1350. Note also the argument considered by Angell that incompetent patients, particularly those in a persistent vegetative state, do not suffer to the same extent as competent patients. See also Browne, 55, n. 79. Although the issue is not specifically addressed in the criteria for active voluntary euthanasia which have been developed by the Dutch courts, in practice, doctors have relied on the advance directives of formerly competent patients; see chapter VIII, n. 232.

¹²⁵ See above, 412-419.

¹²⁶ This is accepted even by those commentators who are opposed to doctors being involved in the administration of active voluntary euthanasia; see, for example, Richards, 418.

¹²⁷ See chapter V, 207-209.

¹²⁸ See chapter V, 211-212.

¹²⁹ Williams, 'Euthanasia,' 666-667; Samek, 115.

¹³⁰ See chapter VIII, 359, 369, 373.

include a requirement of consultation with another doctor to confirm the patient's decision-making capacity, the voluntariness of the patient's request, and the diagnosis and prognosis of the patient's condition. There should be a further requirement of full documentation of both practitioners' findings.¹³¹

Whilst there may be little dispute with medical involvement in ascertaining the eligibility of a patient for active voluntary euthanasia, the more controversial issue is whether doctors should be involved in the actual administration of active voluntary euthanasia. The essence of the opponents arguments on this point is that the deliberate taking of life is completely contrary to the whole ethics and training of the medical profession and would seriously undermine the doctor/patient relationship. These arguments have already been considered in an earlier chapter where it was argued that these concerns are largely unfounded.¹³² Realistically, the alternatives are limited. The possibility of friends or relatives performing active euthanasia at the request of a loved one can be readily discounted. As one commentator has pointed out, friends and relatives are likely to be emotionally involved with the patient and are consequently more likely to be traumatised by the experience if they participate directly in bringing about the patient's death.¹³³ Moreover, active euthanasia is a medical procedure requiring medical and pharmacological expertise. The very nature of the act would therefore suggest that it be performed by a registered medical practitioner. It is certainly true that lay persons or para-professionals could be trained to administer a painless death. However, this would entail its own dangers and problems.¹³⁴ Another possibility would be for health care professionals other than doctors to perform active voluntary euthanasia, for example nurses. There are good grounds though for suggesting that the responsibility for this practice should be confined to doctors. Prominent amongst these considerations is the fact that doctors have the most extensive medical and pharmacological expertise and already have the responsibility of making what are, in effect, life and death decisions. Given the inevitable involvement of the medical profession in ascertaining compliance with the eligibility criteria it would be far preferable for members of the medical profession to also be vested with the responsibility of administering active voluntary euthanasia. And, as was suggested in an earlier chapter, there are other valid reasons why doctors are the most appropriate group to administer active voluntary euthanasia.¹³⁵ Doctors are in close contact with the patient and have direct knowledge of the patient's medical circumstances. Moreover, they are subject to strict codes of professional conduct and medical ethics and can be assumed to be acting in the best interests of the patient.¹³⁶

One interesting suggestion which has been made in order to avoid the involvement of ordinary doctors in the practice of active voluntary euthanasia, is that euthanasia be developed as an area of

¹³¹ See above, 421 for relevant matters which could be covered.

¹³² See chapter V, 217-220.

¹³³ Crisp, 75-76.

¹³⁴ There is, for example, very real concern about extending this kind of knowledge beyond the medical profession because of the risk that it may be misused.

¹³⁵ See chapter V, 218.

¹³⁶ R. Risley, 'In Defense of the Humane and Dignified Death Act' (1988-89) *Free Inquiry* 10, 11-12.

specialisation in medicine.¹³⁷ According to this proposal, active voluntary euthanasia could become an important part of the care provided to the terminally ill. Whilst there would appear to be no major problems in principle with this proposal, its feasibility in practice would depend on the willingness of sufficient numbers of doctors to pursue this area of specialisation. There is also the consideration that if the practice of active voluntary euthanasia was confined to an area of medical specialisation, fewer physicians would be involved in the practice, but they would be called upon to administer active voluntary euthanasia more frequently than if the practice were distributed amongst the medical profession. It is therefore necessary to weigh up the potential advantages of specialisation against the argument that given the extraordinary nature of active voluntary euthanasia, it would be preferable if the practice by any individual doctor would be kept to a minimum.

On balance, the most preferable and realistic proposal is for doctors to be involved in the administration of active voluntary euthanasia. As noted in a previous chapter, there is evidence from survey results indicate that a significant proportion of the medical profession not only support the legalisation of active voluntary euthanasia, but would be willing to engage in the practice if it were legal.¹³⁸ In order for there to be an appropriate balance between personalised knowledge of the patient and objective consultation and decision-making, it would be desirable for this requirement to be framed in terms similar to that presently in operation in the Netherlands; that a medical doctor who is familiar with the relevant circumstances of the case is involved in the decision and the prescription and administration of the correct drugs and that there is consultation with another doctor.¹³⁹ Moreover, the involvement of another doctor would go some way to overcome the objection raised by some commentators of permitting private killings, involving a private transaction between a doctor and his or her patient.¹⁴⁰

If it is decided that it is appropriate for doctors to be involved in the practice of active voluntary euthanasia, either as specialists, or more likely, within the normal course of medical practice, careful consideration would have to be given to the position of those doctors who do not wish to participate. It was argued in an earlier chapter, that under no circumstances should doctors be under a legal obligation to perform active euthanasia at the patient's request.¹⁴¹ This principle could be reflected in the legislation by the inclusion of a conscience clause, making it clear that doctors are free to refuse to participate in the practice of active euthanasia.¹⁴² Alternatively, legislation providing for active

¹³⁷ Crisp, 77; Benrubi, 198. See also Crisp, 77-78 for consideration and rejection of some of the possible arguments against this proposal. Other commentators have also argued that if active voluntary euthanasia is going to be performed by doctors it would be preferable to create a separate profession specifically for this purpose; e.g. D. Vere, *Voluntary Euthanasia* (1971).

¹³⁸ See chapter VI, 265, 266, 277, 282.

¹³⁹ See chapter VIII, 359.

¹⁴⁰ For example, D. Callahan, 'Aid-In-Dying: The Social Dimension' (1991) 118 *Commonweal* 476, 477.

¹⁴¹ See chapter V, 185-187, 201. See also Cole and Shea, 851.

¹⁴² See, for example, the 1969 *Voluntary Euthanasia Bill* (U.K.) cl. 4(3) which provides that 'No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection' and the Californian *Humane and Dignified Death Act* cl. 2525.8 which states that 'Nothing herein requires a physician to administer aid-in-dying if he or she is morally or ethically opposed'. The Californian initiative also granted the physician immunity from civil, criminal and administrative liability for failing to effectuate the directive of a qualified patient, unless he or she wilfully refuses to transfer the

voluntary euthanasia could be framed in permissive terms only, making it clear that doctors who administer active euthanasia at the request of a patient in accordance with the legislation will not be criminally liable, but in no way creating an *obligation* to comply with a patient's request for active euthanasia. A related consideration is whether a doctor who chooses not to be involved in the practice of active voluntary euthanasia should be under a statutory obligation to transfer the patient or refer the patient to another doctor. Some of the legislative proposals for the legalisation of active voluntary euthanasia specifically provide for the transfer of patients in these circumstances.¹⁴³ Although such a requirement would maximise the patient's opportunity to have his or her euthanasia request granted, doctors strongly opposed to the concept of active voluntary euthanasia may find a requirement of this kind to be against their principles.¹⁴⁴ It is therefore probably preferable not to enshrine this in legislation but to leave it to the guidelines for medical practice.

In the light of the current criminal law prohibition of active voluntary euthanasia, an important feature of any proposal for legalisation is the introduction of an immunity to protect doctors from liability when acceding to the patient's euthanasia request. Moreover, doctors engaged in the practice of active voluntary euthanasia must also be protected from civil and disciplinary proceedings. Such immunities have been an integral feature of most of the legislative proposals.¹⁴⁵ Alongside such an immunity, the legislation should also contain a saving provision unequivocally declaring the limits of the legislation, to the effect that nothing in the legislation shall be construed to authorise or permit the deliberate taking of life other than in accordance with the legislation.¹⁴⁶ Provided that there is some provision to this effect making it abundantly clear that the current criminal law prohibitions continue to apply to cases falling outside the legislation, it is probably unnecessary to include specific penalties in the legislation.¹⁴⁷

patient upon request. A similar provision was contained in the legislation proposed under the Washington Initiative 119 and in the proposal for physician aid-in-dying in the 1992 California campaign. See further, chapter VII, 341-343. Note also the legislative proposal of the State Commission on euthanasia in the Netherlands; see chapter VIII, 373.

¹⁴³ See, for example, the Californian *Humane and Dignified Death Act* cl. 7191 which provides 'A failure by a physician to effectuate the directive of a qualified patient pursuant to this division shall constitute unprofessional conduct if the physician refuses to make arrangements, or fails to take reasonable steps, to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient; see R. Risley and M. White, 'Humane and Dignified Death Initiative for 1988' (1986) 1 *Euthanasia Rev.* 226, 230-231. Note also Brandt *et al.*, 194, 199-200.

¹⁴⁴ D. Shewmon, 'Active Voluntary Euthanasia: A Needless Pandora's Box' (1987) 3 *Issues Law & Med.* 219, 212.

¹⁴⁵ See, for example, the 1969 *Voluntary Euthanasia Bill* (U.K.) cl. 5(1) which provides that a physician or nurse who, acting in good faith, causes euthanasia to be administered to a qualified patient in accordance with what that person so acting believes to be the patient's declaration and wishes, shall not be guilty of any offence. Clause 5(2) states that physicians and nurses who have taken part in the administration of euthanasia shall be deemed not to be in breach of any professional oath or affirmation. See also the Californian *Humane and Dignified Death Act* cl. 7190 which provides for an immunity from criminal, civil and administrative proceedings. Note also cl. 7195; see Risley and White, 230, 232. A similar provision was contained in the Washington Initiative 119 and appears in the 1992 Californian proposal. For a discussion of these legislative proposals, see chapter VII, 319, 339-343. Note also Brandt *et al.*, 196-197; Cole and Shea 856.

¹⁴⁶ See cl. 2443 under the *Humane and Dignified Death Act* proposed in California; see Risley and White, 232.

¹⁴⁷ For an example of a proposed Bill with comprehensive penalties for non-compliance with the legislation, see Brandt *et al.*, 198-202. Note also the recommendations of the Netherlands State Commission on euthanasia; see chapter VIII, 373.

Witnessing Requirements for the Administration of Active Voluntary Euthanasia

A procedural safeguard included in a number of the proposals for legislative reform is that the administration of active voluntary euthanasia must be performed in the presence of witnesses.¹⁴⁸ This requirement has considerable merit. One of the principal arguments for the legalisation of active voluntary euthanasia is that the practice can be brought into the open and appropriately regulated.¹⁴⁹ A requirement that active voluntary euthanasia be performed in the presence of suitable witnesses would provide an important check on the procedure and provide some protection against the possibility of error and abuse.

Reporting Requirements

A final matter that needs to be addressed is whether there should be any formal reporting requirements imposed under the legislation which must be complied with by a doctor who has performed active voluntary euthanasia. As noted above, one of the key arguments for the legalisation of the practice is that it can be performed openly and subject to public scrutiny.¹⁵⁰ Consistent with this objective, doctors should be required to keep proper records with regard to the administration of active voluntary euthanasia. However, in developing an appropriate reporting procedure, caution must be exercised in avoiding a procedure that is unnecessarily intrusive and bureaucratic. A fundamental requirement would be that the cause of death recorded on the patient's death certificate would be medically administered active voluntary euthanasia as opposed to natural causes. It also follows from the foregoing recommendations that there would be documentation of the patient's request for active voluntary euthanasia¹⁵¹ as well as documentation from the patient's doctor and the consultant doctor regarding the patient's decision-making capacity, the voluntariness of the patient's request, and the diagnosis and prognosis of the patient.¹⁵² One could go further and require the routine investigation or review of all cases of medically administered active voluntary euthanasia by the police or other investigative body, but in the light of the strict safeguards which have been suggested which necessarily entail independent scrutiny of the doctor's practices¹⁵³ such a requirement would be unwarranted. In the event that a complaint or allegation is made that some aspect of the legislation has not been complied with, an independent investigation would of course be necessary.

¹⁴⁸ See, for example, the *Voluntary Euthanasia (Legalisation) Bill* 1936 (U.K.) which required that active euthanasia must be administered in the presence of an 'official witness'. The latter must be a justice of the peace, or a barrister, solicitor, medical practitioner, clergyman or other minister of religion, or a State registered nurse. Note also the 1938 New York Bill which required that active euthanasia be administered in the presence of the euthanasia committee, or two members thereof; see Levisohn, 70.

¹⁴⁹ See chapter IV, 149-150 and chapter V, 191-192.

¹⁵⁰ See above, text accompanying n. 149.

¹⁵¹ See above, 418-419.

¹⁵² See above, 422.

¹⁵³ For example, the requirement of consultation with another medical practitioner and the witnessing requirements with regard to both the patient's request and the actual administration of active euthanasia.

Conclusion

The object of this chapter has been to critically evaluate the various possible models for change with regard to the law dealing with active voluntary euthanasia. In addition to the useful guidance and direction available from the many proposals which have been advanced over the years, particular assistance has been derived from a consideration of the Netherlands model for the practice of active voluntary euthanasia.

After considering a number of possible legislative solutions, it is suggested that outright legalisation of active voluntary euthanasia would be the most appropriate course, subject to strict safeguards. The criteria and safeguards for the performance of active voluntary euthanasia recommended in this chapter mirror, to a large extent, the criteria presently in use in the Netherlands for the practice of active voluntary euthanasia.¹⁵⁴ They are both practicable and workable¹⁵⁵ and this is borne out by the experience in the Netherlands. It is therefore possible to provide adequate safeguards for the performance of active voluntary euthanasia without bureaucratizing the sick room and invoking cumbersome safeguard machinery.

It is readily acknowledged that a number of the criterion and safeguards which have been recommended considerably limit the scope of any reform, by, for example, stipulating that the availability of active voluntary euthanasia be confined to patients who presently have decision-making capacity, and who have a serious incurable condition which the patient finds unbearable. However, safeguards of this kind are necessary for the protection of both doctors and their patients. Given the significance of any change in this area it is appropriate to proceed cautiously and to set clear parameters which confine the practice. Whilst it is argued here that legislative measures should be introduced which permit the performance of active voluntary euthanasia in clearly specified and carefully regulated circumstances, it is at the same time, strongly recommended that suitable barriers are maintained against the deliberate taking of human life.

With regard to implementation of the proposed legislative reforms, there is much to be said for keeping the legislation as simple and streamlined as possible. It should consist of a concise legislative statement containing the key elements of the foregoing recommendations, leaving the finer details to regulations and guidelines for medical practice. By its very nature, euthanasia reform is an area where an interdisciplinary approach is essential and the medical profession has an important role to play in providing input into this process.

As a final rider to legislative reform in this country, it should be noted that because the area of criminal law comes within the jurisdictions of the Australian States and Territories, implementation

¹⁵⁴ As explained in chapter VIII, 355, in the Netherlands these criteria are not presently in statutory form.

¹⁵⁵ See, however, the claims of opponents, such as Y. Kamisar ('Some Non-Religious Views Against Proposed Mercy-Killing Legislation' (1958) 42 *Minn.L.Rev.* 969, 982) to the effect that it is impracticable to devise a suitable proposal for the legalisation of active voluntary euthanasia; see chapter V, 213-214.

of any reform would have to occur at the State and Territory level. This presents practical difficulties in securing uniformity throughout Australia with regard euthanasia legislation, and success can only be achieved through the co-operative efforts of all Australian jurisdictions.

CONCLUSION

Active voluntary euthanasia is a notoriously complex and controversial issue. This thesis is by no means the last word on the subject but simply a contribution in a vast debate which is developing at an accelerating pace and becoming increasingly prominent.

On the basis of the analysis in the foregoing chapters, some matters can be stated with relative certainty. It is clear from the analysis of the criminal law that there is a sharp distinction in the law's approach to passive and active euthanasia. Whilst the law recognises the patient's right to refuse treatment and permits passive euthanasia in certain circumstances, active voluntary euthanasia is unequivocally prohibited as murder regardless of the special mitigating circumstances usually existing in such cases. Notwithstanding the legal prohibition, there is substantial evidence that active voluntary euthanasia is already being performed by doctors in Australia, although it is largely a hidden practice. No doctor in Australia has been prosecuted for performing active voluntary euthanasia and, from the experience in other jurisdictions, there is every possibility that if a prosecution did arise in a genuine euthanasia case, the doctor would escape the full rigours of the criminal law. However, as the recent prosecution of Dr Cox in the United Kingdom has shown,¹ this cannot be relied upon as a certainty, and doctors who compassionately assist their patients to die run the risk of incurring serious criminal liability. Against this background, there is incontrovertible evidence of increasing support for active voluntary euthanasia amongst the medical profession and in the community generally. It also appears to be beyond dispute that problems arise when a particular law no longer commands respect or support. On the basis of these findings, it can be concluded that there is now a definite body of evidence which suggests that the present law does not meet social needs and that change is in the community interest. There is, therefore, a strong case for the reappraisal of the present legal prohibition of active voluntary euthanasia.

In assessing the appropriateness of reform in this area, valuable assistance has been gained from the experience in the Netherlands. Although not actually legal, active voluntary euthanasia has been openly practiced in that country for some years and has been officially sanctioned by the courts and the prosecuting authorities. This is clearly not equivalent to legalisation of the practice, but the Netherlands experience does, nevertheless, provide some opportunity for empirically testing claims about the harmful effects of State sanctioned active voluntary euthanasia. A careful examination of the practice in the Netherlands does not support the assertions made by opponents of euthanasia, and in fact demonstrates that active voluntary euthanasia can be safely incorporated into medical practice, subject to certain well defined criteria. It must be recognised however, that regardless of its intrinsic

¹ See chapter IV, 126-127.

merit, the model for the practice of active voluntary euthanasia which has been developed in the Netherlands is not necessarily the appropriate solution for other countries contemplating reform in this area. It is, therefore, vital to view the Netherlands' practice in its wider context and to be culturally sensitive in developing solutions to the problem of active voluntary euthanasia. So, whilst acknowledging that the practice of active voluntary euthanasia developed in that country may not be the answer for all jurisdictions, it has been demonstrated that it provides an appropriate model for law reform in Australia. It may also be a suitable model for consideration in a number of the other jurisdictions under consideration, including the United Kingdom, but serious reservations must be raised regarding its suitability in the United States due to significant differences in that countries health care and legal systems.²

Examination of options for reform in this area requires consideration of legislative solutions. This is by no means to suggest that legislation should be the inevitable response to a legal problem, particularly in the field of law and medicine where a myriad of complex ethical and professional issues are involved. Clearly, legislation is not a universal panacea or omnipotent force, and there are, in fact, many difficulties and limitations associated with legislative solutions. To begin with, the legislative process is subject to many pressures and constraints³ and the outcome of this process is often the product of political compromise. This may, in many instances, jeopardise or even undermine the integrity of the legislation. Moreover, legislation can never hope to be exhaustive, and the potential always exists for difficulties in the interpretation of the legislation. There are also problems with the inflexibility of legislative solutions. Once enacted, statute law is in force until such time it is amended or repealed and is far less amenable to change than judge made law which can be more directly responsive to the fluctuating demands of society.⁴ A further limitation on the operation of legislation is that it is often, on its own, not a complete answer to the difficulties raised. In many instances, legislation will only be successful in achieving its aims if it is accompanied by an educational campaign and the allocation of appropriate resources.

In view of these various limitations, there is every reason to reflect carefully before proceeding to a legislative solution and to give due consideration to alternative remedies such as changes in institutional practices or the introduction of voluntary codes of self-regulation.⁵ However, notwithstanding its shortcomings, in some instances legislation is a necessary and, indeed, an appropriate response. With regard to the present subject of active voluntary euthanasia, in view of the unequivocal prohibition of the practice under the criminal law, any substantive change could only be achieved through legislation. Nothing short of legislative reform would suffice to provide doctors who practice active voluntary euthanasia with the necessary immunity from criminal

² M. Pabst Battin, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices' in O. Aycke and M. Smook, (eds.) *Right to Self-Determination*, Proceedings of the 8th World Conference of the Right to Die Societies (1990) 124; M. Battin, 'Seven Caveats Concerning the Discussion of Euthanasia in Holland' (1990) 34 *Perspectives in Biology & Med.* 73.

³ W. Twining and D. Meyers, *How to Do Things With Rules* (2nd ed., 1982) 293.

⁴ For a critique of the inflexibility of statute law and suggestions for change see G. Calabresi, *A Common Law for the Age of Statutes* (1982).

⁵ Twining and Meyers, 303.

liability. Moreover, there are strong arguments (summarised below⁶) to support the view that legalisation of active voluntary euthanasia by legislative enactment would be beneficial. The conclusion of this thesis is, therefore, that on balance, after carefully weighing up the advantages and disadvantages of a legislative solution, legislative reform is both necessary and appropriate.

In the formulation of legislative reform in this country, considerable guidance can be derived from the guidelines for the practice of active voluntary euthanasia which have been developed by the Dutch courts. However, the practice in that country has not been given statutory force so the introduction of legislation permitting active voluntary euthanasia will still be largely experimental.⁷ Nevertheless, it has been argued that there are compelling reasons why we have an obligation to try and secure reform in this area. It is recommended that a very limited exception to the homicide laws be introduced conferring on doctors an immunity from liability, provided active voluntary euthanasia is performed in accordance with strict criteria and safeguards. It must be emphasised that this would not create a 'right' to active voluntary euthanasia but would simply empower doctors to comply with patients' requests in appropriate cases. It is of vital importance that the parameters of any such reforms are clearly defined and that the existing prohibition on taking of life remains to protect individuals from being killed without their consent.

The legalisation of active voluntary euthanasia through legislative reform is unquestionably a significant step for a society to take, and concerns have understandably been raised about the implications of incorporating into law and public policy a practice which allows doctors to kill their patients. Indeed, we have seen that many people who are in principle prepared to accept the legitimacy of active voluntary euthanasia in some circumstances are opposed to the prospect of introducing legislation which would legalise and thereby institutionalise the practice. They are, instead, prepared to tolerate the existing discrepancies between law and practice and the subterfuge which occurs with the practice of active voluntary euthanasia. The essence of this thesis is that the present problems which have been identified must be more honestly and directly addressed, and we need to overcome what is an understandable resistance to contemplate the deliberate taking of life. It is certainly true that legalisation of active voluntary euthanasia implies ethical approval of such conduct,⁸ but the practice of active voluntary euthanasia in appropriate circumstances already enjoys widespread ethical approval, so legalisation would simply be formalising the present situation.

Moreover, it has been argued that there are significant advantages to be gained from legalisation of active voluntary euthanasia. It will promote the autonomy and self-determination of patients by giving eligible patients the freedom to choose active voluntary euthanasia. Although only a small minority of patients are likely to exercise this option, it is important that the option is made available and that patient choice is maximised. Another advantage to be gained from legalisation of active voluntary euthanasia is that it will instil some equilibrium into the law; a suffering patient

⁶ See below, 430-431.

⁷ A. Browne, 'Assisted Suicide and Active Voluntary Euthanasia' (1989) 11 *Can.J.L.Juris.* 35, 55.

⁸ H. Silving, 'Euthanasia: A Study in Comparative Criminal Law' (1954) 103 *U.Pa.L.Rev.* 350, 388.

will not only have the choice of refusing treatment which may bring about his or her death, but may seek more active assistance in dying. Legislative reform will thereby address the present inconsistency in the law which gives a patient the legal authority to direct that no further treatment be administered but holds that a patient cannot give a legally effective consent to having his or her life terminated.

There will also be significant benefits for the medical profession if active voluntary euthanasia is legalised which are ultimately in the interests of good medical practice. Doctors who are already involved in the practice would no longer need to fear the possibility of criminal prosecution, provided they comply with the statutory criteria. Other doctors, who presently refrain from the practice for fear of prosecution, would be free to respond to patients' requests for active euthanasia in appropriate circumstances. Indeed, there is already evidence to suggest that a significant proportion of doctors would be willing to participate in the practice if it were legalised. One of the important advantages of legalisation of active voluntary euthanasia is that it would encourage greater visibility and more open scrutiny of the practice. So long as the practice remains illegal, it is likely to be performed in secrecy, without the benefit of professional discussion and guidance, essential for good medical practice. By specifying criteria and procedures for the lawful performance of active voluntary euthanasia, legislative reform would reduce the risk of unacceptable practices and abuse and patients would, therefore, have a greater measure of protection than they presently have. Doctors who feel compelled to respond to a patient's plea for active euthanasia would be given appropriate legal immunity and there would generally be greater certainty and predictability in the law. It would, however, be naive to assume that the introduction of legislation would remove all difficulties. Obviously, one cannot completely eliminate the possibility of unacceptable practices and abuse, and cases will undoubtedly arise falling outside the statutory exception. Such cases should continue to be dealt with according to the existing criminal law prohibition. There is no evidence to suggest that the legalisation of active voluntary euthanasia would increase the incidence of such cases; to the contrary, there are good grounds for the belief that the risk of unacceptable practices would be reduced.

Whilst some propositions can be stated with certainty, some areas of uncertainty remain. The limitations of the legislative solution which has been proposed must be recognised. Its scope is restricted to active voluntary euthanasia and only provides relief to presently competent adult patients in certain carefully defined circumstances. This admittedly leaves many areas unresolved, including the difficult question of incompetent patients. Whilst detailed consideration of this category of patients (including the crucial question of determining whether a patient has decision-making capacity) falls outside the scope of this thesis, indications are that it would be inappropriate and potentially dangerous to attempt to extend any proposal for legalisation of active voluntary euthanasia to incompetent patients. It is evident from the experience with regard to passive euthanasia that even in circumstances where a formerly competent patient has expressed his or her wishes in an advance directive or living will, problems frequently arise. The difficulties are even

greater if the decision-making responsibility falls upon others, particularly in circumstances where the patient has never been competent and the wishes of the patient can therefore not be known. In these circumstances, decision-making almost inevitably involves assessment of the patient's 'quality of life' and requires a subjective determination of when a person's life is devoid of value, with the inherent difficulties and dangers which that entails.

There are a number of other areas of uncertainty which have been identified but the detailed resolution of which falls beyond the scope of this thesis. In developing the arguments in this thesis, attention was drawn to two particular areas of medical practice which reveal the inconsistencies between the law and practice in this area; the termination of life-support equipment and the administration of pain-relieving drugs which hasten death. Consideration of these areas was incidental to the central issue of active voluntary euthanasia, but nevertheless highlighted the possible need for legislative reform also in these circumstances. Although there has been a tendency toward characterising these medical practices in such a way as to avoid the imposition of criminal liability, the possibility remains that doctors may face criminal prosecutions for acts which are widely regarded as appropriate medical practice. It is, therefore, suggested that there is a case for clarifying the law with regard to these matters, and bringing it into line with common understanding and existing medical practice. This could be achieved by the introduction of a simple legislative provision.⁹

Another unresolved issue raised in this thesis is the question of mercy killing cases outside the medical context. Such cases certainly place a strain on the legal system as discrepancies inevitably arise between law on the books and the law in practice. It is clearly beyond the scope of this thesis to present a conclusive statement as to what should be done in this area, but it is perhaps appropriate for certain words of caution to be expressed. Mercy killings in the family context are quite distinct from medically administered euthanasia and have their own peculiar difficulties. Because of the possibility of self-interest being the motivating factor behind such killings, care must be taken that any proposal for reform does not encourage killings of the sick and elderly, performed *mala fides* under the guise of mercy killing. Moreover, it should be noted that if, in accordance with the recommendations in this thesis, medically administered active voluntary euthanasia was a legally available option, the justification for many of the mercy killing cases would disappear. In these circumstances, reform of the law specifically with regard to mercy killing may well be unnecessary, other than perhaps to ensure that a sentencing discretion exists in all jurisdictions, allowing for the lenient treatment of mercy killers.¹⁰

In conclusion, it is submitted that the time has come for the issue of medically administered active voluntary euthanasia to be squarely confronted and for suitable legislative reform to be developed. It

⁹ With regard to the issue of administration of drugs which may hasten death, a number of legislative formulations have been advanced for consideration. See, for example, the proposals made by the West Australian and Canadian Law Reform Commission discussed in chapter VII, 313 and 347 respectively.

¹⁰ For consideration of proposals for reform in this area, see the discussion in chapter VII, 291-293 and 321-322.

must, however, be acknowledged that irrespective of how well or carefully a legislative solution is formulated, it can at best be a partial response to the difficulties which are encountered by many patients, and the importance of non-legal solutions must not be underestimated. Active voluntary euthanasia should not be a substitute for alternative forms of care such as palliative and hospice care, but rather should be seen as a last resort available to patients in circumstances where all other available options have been carefully canvassed. It is, therefore, of the utmost importance that the developments in palliative and hospice care be continued in order that patients are assured of adequate pain relief, control of symptoms, and treatment of psychological distress.¹¹ There should also be continuing attention given to the needs of the sick and dying generally, with emphasis on better training of health care professionals and improved communication with patients. The development of optimal palliative and hospice care obviously requires appropriate government expenditure in these areas, but society has an obligation to do all that is reasonably possible to improve the situation of dying and suffering patients. The provision of comprehensive care would certainly go some way towards minimising the need for active voluntary euthanasia and ensuring that lives are not unnecessarily terminated. It cannot, however, provide a solution in all cases and active voluntary euthanasia must be an option available to all patients.

¹¹ K. Foley, 'The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide' (1991) 6 *Journal of Pain & Symptom Management* 289.

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